COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services

OPERATION MANUAL
Volume X

OMTL-329

Table of Contents POLICY UPDATES R. 4/1/09

End of Volume X

MS 99782 TAX REBATE CHECKS

Starting in May, 2008 and continuing through the summer the U.S. Treasury will send tax rebate checks to more than 130 million individuals.

A. For K-TAP cases, rebate checks are considered excluded income and resources.

B. For Medicaid and Food Stamp cases, the rebate checks are considered in the following manner:

1. In the month of receipt and the following two months rebate checks are considered excluded income and resources.
2. Any proceeds from this rebate retained after the third month shall then be considered a resource.
3. For vendor payment recipients, i.e., NF or Waiver cases, the funds must be disposed during the month of receipt or the following two months. Any funds remaining after that point will be a countable resource.

Rebate checks will be subject to offset against outstanding tax and non-tax liabilities in the same fashion as regular tax refunds.

Patricia R. Wilson, Commissioner

Volume II
The following manual section is cross-referenced with this update: MS 5210
Volume III
The following manual section is cross-referenced with this update: MS 2510
~~Volume IV~~
~~The following manual sections are cross-referenced with this update:~~ ~~MS 4320 and MS 4385~~
Volume IVA
The following manual sections are cross-referenced with this update: MS 1880 and MS 2465

MS 99779 CHILD CARE CLAIMS ON KCD

Effective February 4, 2008, all Child Care claims will be entered on the Kentucky Claims Debt (KCD) Management System by the Child Care Assistance Program staff in Central Office.

A. New categories for Child Care claims are created. The individual categories are as follows:

1. CAE (Child Care Agency Error);
2. CNC (Child Care Non-Court);
3. CCC (Child Care Court); and
4. CEF (Child Care Employee Fraud).

B. A daily RDS and DocumentDirect report will be created to list all Child Care recipients who are over 90 days delinquent with a claim payment.

Patricia R. Wilson, Commissioner

Volume I
The following manual sections are cross-referenced with this update: MS 1525, MS 1668, MS 1670, MS 1688, and MS 1690

MS 99778 CHANGES IN RESTORATION AND SUPPLEMENTAL PROCESSING

Effective February 4, 2008, restorations and supplemental benefits manually issued for Food Stamp cases and supplemental benefits manually issued for K-TAP, Kinship Care and State Supplementation cases will pend for supervisory approval.

A. When an individual other than a supervisor or a SAFE worker initiates a restoration or supplemental benefits action, the message "ACTION PENDED-GIVE FILE TO SUPV/PRINC" appears. This includes actions initiated by principals. A principal worker is not able to sign off his/her own action.

B. The case file must be taken to the principal or supervisor for a separate sign off. In order to successfully sign off an issuance, the supervisor or principal must be logged on to KAMES in his/her own "HRII" code.

C. If the restoration or supplemental action is not appropriately signed off the same date the action is initiated, the worker and supervisor receive a pending case change DCSR message the next work day stating, "AWAITING APRVL – SUPPLEMENTAL" or "AWAITING APRVL – RESTORATION".

Mark Cornett, Deputy Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 1721
Volume VI
The following manual sections are cross-referenced with this update: MS 5350 and MS 5405
Volume X
The following manual section is cross-referenced with this update: MS 99688

MS 99775 IRS SAFEGUARDING ISSUES

Effective November 1, 2007 reasons for failing to safeguard IRS information will also include the unauthorized inspection as well as unauthorized disclosure of information.

Upon discovery of a possible unauthorized inspection or the discovery of unauthorized disclosure of Federal Tax Information (FTI) by a Federal employee, a State employee, or any other person, the individual making the observation or receiving the information should contact the office of the appropriate Treasury Inspector General for Tax Administration (TIGTA) at:

Treasury Inspector General for Tax Administration
P.O. Box 589, Ben Franklin Station
Washington, DC 20044-0589
Phone: (513) 263-3040
Toll-Free 1-800-366-4484

Mark Washington, Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 1915

MS 99773 Entering Out-of-State IPV Disqualifications

Because workers must enter Food Stamp Intentional Program Violation (IPV) disqualifications listed on the Disqualification Recipient Subsystem (DRS) in order to track occurrences, system changes are made to allow KAMES to match the out-of-state disqualification information from the DRS. Disqualifications on the DRS appear monthly on RDS report KIFJ14-KAME/DRS.

Effective 11/12/07, a new question will appear on the KAMES Disqualification Menu. The question "Is This an Out-of-State FS IPV Disqualification on DRS?" will require the worker to answer "Y" or "N" depending on the dates of the out-of-state disqualification.

If the out-of-state IPV disqualification listed on the DRS report has already been served (the "through date" is a past date) and has not already been added to KAMES, the worker answers "Y" to the new question. This opens a new screen that allows the disqualification information to be added to the KAMES disqualification file exactly as it appears on the DRS report.

If the out-of-state IPV disqualification includes a current or future date and is not already entered on KAMES then "N" is answered. The regular KAMES disqualification screen appears allowing the worker to enter the DRS information in the current KAMES disqualification fields. If the worker answers "Y" to the question and attempts to enter current or future disqualification dates, KAMES will display an error message.

In addition to the new screen for adding out-of-state disqualifications on KAMES, new screens for changing/updating out-of-state IPV disqualifications, deleting out-of-state IPV disqualifications, and inquiring the out-of-state IPV disqualifications are added. Supervisory approval will be required of probationary workers deleting or changing out-of-state disqualifications and of workers entering deletions.

Mark Washington, Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 1659
Volume VI
The following manual section is cross-referenced with this update: MS 5720
Volume X
The Table of Contents is revised to add OMU No. 07-24, MS 99773, 11/12/07

MS 99772 FOOD STAMP CHANGES

Effective 10/1/07, cash benefits were added to the EBT card. As a result, the following procedures must be followed when the head-of-household changes in a Food Stamp case.

A. If the head-of-household is deceased:
   1. Discontinue the current food stamp case;
   2. Complete a new application in the new head-of-household's name;
   3. Conduct an interview, obtain a signature and appropriate verification;
   4. Issue a new EBT card in the new head-of-household's name if needed;
   5. All new benefits issued will be accessed with the new EBT account and card; and
   6. Advise the household that they may continue to utilize the benefits issued on the old EBT card until the benefits are exhausted.

B. If the head-of-household moved out:
   1. As the head-of-household has changed residency, and as this is a change know to the agency, take appropriate action;
   2. Remove the remaining household members from the current food stamp case;
   3. Complete a new application in the new head-of-household's name;
   4. Conduct an interview, obtain a signature and appropriate verification;
   5. Issue a new EBT card in the new head-of-household's name if needed.
   6. All new benefits issued will be accessed with the new EBT account and card.

Mark Washington, Commissioner

Volume VI
The following manual section is cross-referenced with this update: MS 4470
Volume X
The Table of Contents is revised to add OM Update No. 07-23, MS 99772, 11/1/07

MS 99770 CHANGES TO ELECTRONIC BENEFIT TRANSFER FOR ISSUANCE OF K-TAP AND KINSHIP CARE

See OMTL-329, 4/1/09

Electronic Benefit Transfer (EBT) is being implemented as a method of issuing K-TAP and Kinship Care benefits. Direct deposit remains an option for K-TAP and Kinship Care recipients. All other payments such as Work Incentive Reimbursement (WIN), supportive services, etc. continue to be issued by a check.

A major change associated with the transition to EBT is benefit amounts under $10 will be issued whether by EBT, direct deposit or check. This begins statewide 11/1/07 with the first and second issuances.

Individuals who have an EBT card for Food Stamp benefits will not receive a new EBT card for K-TAP or Kinship Care benefits. The same EBT card is used to access all K-TAP, Kinship Care and Food Stamp benefits issued to that individual.

All program requirements for EBT remain unchanged for Food Stamp cases. However, there were some KAMES modifications to accommodate cash on EBT which also affect Food Stamp processing. These modifications are addressed in this update.

Implementation of EBT for cash benefits will occur in two phases.

A. Phase one begins 10/1/07 in the three pilot counties of Kenton, Franklin and Pike.

1. Effective 10/1/07, the benefits issued from daily issuance are deposited to an EBT account unless direct deposit is in place. The direct deposit cases remain the same until the individual requests otherwise.

    a. Benefits for cases approved on or after 10/1/07 in Kenton, Franklin or Pike counties are deposited to an EBT account. If an individual opts for direct deposit at approval, the benefits are issued to the EBT account until direct deposit is in place.
    b. Supplemental benefits resulting from case change actions on KAMES are deposited in the EBT account, including direct deposit cases, unless benefits are authorized by special circumstance. If benefits are authorized by special circumstance, the benefits are issued by a check.

2. As the first and second issuance of the monthly benefits for 10/07 occurs in 9/07, those benefits are issued by a check. Starting with benefits for 11/07, first and second issuance of the monthly benefits will be deposited to the EBT account unless direct deposit is in place.

3. If the individual moves from an EBT county to a non EBT county during phase one, the benefits are issued by check beginning with the effective month the county code is changed on KAMES. Once the county implements EBT, then

the benefits are issued to the EBT account. The individual can still access any benefits left on the EBT account.

If the individual moves from a non EBT county to an EBT county, the benefits are issued to the EBT account beginning with the effective month the county code is changed on KAMES.

B. Phase two begins 1/1/08 for the remaining counties.

1. Effective 1/1/08, the benefits issued from daily issuance are deposited to an EBT account. Direct deposit cases remain in place until the individual requests otherwise.

   a. Benefits for cases approved on or after 1/1/08 are deposited to an EBT account. If the individual opts for direct deposit at approval, the benefits are issued to the EBT account until direct deposit is in place.
   b. Supplemental benefits resulting from case change actions on KAMES are deposited in the EBT account, including direct deposit cases, unless benefits are authorized by special circumstance. If the additional benefits are authorized by special circumstance, the additional benefits are issued by a check.

2. As the first and second issuance of the monthly benefits for 1/08 occurs in 12/07, those benefits are issued by a check. Starting with benefits for 2/08, first and second issuance of the monthly benefits will be deposited to the EBT account unless direct deposit is in place.

C. Each local office is responsible for providing all households with an explanation of the EBT issuance process. The Field Services Supervisor (FSS) is responsible for:

1. Maintaining security and control of EBT cards which are sent to the local office for pickup;

2. Retaining all issuance records for audit purposes for at least five years or for a longer period of time, if requested in writing; and

3. Ensuring K-TAP and Kinship Care case information is accurately entered on KAMES.

D. Cash benefits on the EBT system can be accessed by the individual in the following ways:

1. The individual can withdraw cash at an Automatic Teller Machine (ATM) which displays the Quest logo. The individual gets one free withdraw per month with no fee. The individual is charged a fee of 85 cents per withdraw after the first withdrawal. The individual will also be assessed normal bank charges if the ATM charges a processing fee. The fee is deducted from the EBT account.

2. The individual can withdraw cash at a retailer's point of service (POS) terminal at authorized retailers without charge at the time of a retail

purchase. Individuals cannot request cash back from the Food Stamp portion of the EBT account.

3. Funds may be saved from month to month, but the account must be used at least once within a 12-month period or benefits may be expunged. Spot checks will be received at 3 and 9 months to alert the worker to contact the individual to determine why benefits have not been accessed.

E. Even with the discontinuance of a Food Stamp, K-TAP and/or Kinship Care case any remaining benefits may continue to be accessed from the EBT account.

F. When problems or questions arise with the EBT card and/or Personal Identification Number (PIN), the individual may contact the Customer Service Representative (CSR) help line at 1-888-979-9949. The telephone number is printed on the back of the EBT card and on the training material the individual receives in the mail.

1. The CSR is operational 24 hours a day, 7 days a week and is voice automated. Individuals may call from a touch-tone phone or a rotary dial phone. If calling from a rotary dial phone, the individual is instructed to stay on the line to speak with a representative.

2. The CSR is contacted to:

   a. Report a lost, stolen, or damaged EBT card, and request a new EBT card;
   b. Activate an EBT card. To activate the EBT card, the individual must provide the 16-digit EBT card number and the primary recipient's date of birth MMDDYYYY;
   c. Check the benefit balance;
   d. Review the last 10 transactions; and
   e. Select and/or change a PIN number.

3. All certified retailers are provided with a toll-free telephone number for use when problems arise with their equipment or completing a transaction. These numbers are:

Retailer HELP DESK	
EBT only	1-800-230-0179
Integrated	Call your Third Party Processor
Manual Voucher Approval	1-866-340-9520
Retailer General Questions	1-800-350-8533

These numbers are printed on the training material the retailers receive.

G. During the certification interview, provide the household with the following explanations about EBT:

1. EBT is the method used to deliver benefits in Kentucky. EBT provides a safer, more secure method for an individual to receive benefits. EBT also eliminates the need to mail or have the individual pick up his/her benefits each month. Benefits are simply added to the individual's EBT account when an issuance is processed.

2. EBT cards are the size and shape of typical bank credit cards. The card is red, white and blue with an American flag design. The EBT card contains the primary person's name and EBT card number.

3. All EBT cards are mailed with an inactive status. The card should be received in approximately 7 days. The individual receives an EBT card with a sticker attached advising him/her to call the CSR to activate the card. If the card is not activated by this call, the card will not work.

4. Only one EBT card is issued to a social security number (SSN) regardless of the number of cases in their name and SSN. Individuals who have an EBT card for Food Stamp benefits will not receive a new EBT card for K-TAP or Kinship Care benefits. The same EBT card used to access Food Stamp benefits is used to access K-TAP and Kinship Care benefits.

   EXAMPLE #1: Mom has a K-TAP, Food Stamp and Kinship Care case. All three cases are in her name and SSN. Mom is issued one EBT card for all benefits.

   EXAMPLE #2: Mom and Dad have a K-TAP and Food Stamp case in Dad's name and SSN. Mom has a Kinship Care case in her name and SSN. Dad is issued an EBT card for the K-TAP and Food Stamp benefits. Mom is issued an EBT card for Kinship Care benefits.

5. The EBT card is mailed in a card carrier, which is a two-sided heavy paper folder with slots cut to hold the card in place during mailing. Supplemental EBT educational information is printed on the card carrier covering such subjects as:

   a. How and where to use the card;
   b. How and when to use the CSR;
   c. How to protect the card;
   d. The need for PIN security; and
   e. A non-discrimination statement.

6. Regular monthly cash benefits are available to EBT recipients at 5:00 a.m. on the 1st day of each month. Supplementals and and other daily benefits are available to recipients at 5:00 a.m. the day following issuance.

7. Individuals can activate the EBT card, choose the four-digit PIN and check the card balance by calling the CSR toll-free telephone number, 1-888-979-9949.

8. EBT system problems are handled by customer service support 24 hours a day, 7 days per week for recipients and retailers.

H. EBT cards are normally sent to the individual's mailing address as listed on KAMES. However, in certain situations, when an individual does not have a secured mailbox, the EBT card can be mailed to the local office by answering the question "DO YOU WANT EBT CARD MAILED TO CLIENT OR LOCAL OFFICE?"

   The question must be answered with "C" indicating the client address or "O" indicating the local office address.

I. For security of EBT cards, see Vol. II, MS 8030.

J. In the event that a need for a protective payee is identified, enter the protective payee information on KAMES. However, the protective payee information is not transmitted to the EBT system. EBT benefits are issued to the individual. The protective payee will need to work with the individual to oversee the use of the benefits. The protective payee can use the card in the same manner as the authorized representative in the food stamp case.

K. K-TAP and Kinship Care cases on benefit reduction due to claims will remain on benefit reduction.

L. Cash benefits are subject to expungement.

1. An EBT account for K-TAP and Kinship Care benefits must be debited by the individual at least once every 12 months, or benefits may be removed/expunged. If the individual fails to debit their EBT account for a 12-month period, a letter is sent detailing the procedure for expungement. Cash expungement policy differs from food stamp policy. For policy on expungement of Food Stamp benefits, refer to Vol. II, MS 8110.

2. For active K-TAP and Kinship Care cases a spot check stating, "NO ACTIVITY CASH ACCT PAST 3 MO" will post to a worker's DCSR and will stay for 10 days if there has been no activity for 3 months on the cash EBT account. The spot check must be manually removed by the worker. The worker must contact the individual to investigate why benefits are not being used, explaining the benefits will be expunged after 12 months of no activity.

3. For active K-TAP and Kinship Care cases, after 9 months of inactivity on the cash EBT account, a spot check stating, "NO ACTIVITY CASH ACCT PAST 9 MO" will post to a worker's DCSR and will stay for 10 days. The spot check must be manually removed by the worker. The worker must contact the individual to investigate why benefits are not being used, explaining the benefits will be expunged after 12 months of no activity.

4. Some or all of the benefits in the account are expunged after inactivity of 365 days. When the benefits are expunged, they are deducted from the recipient's EBT account.

   a. When the EBT cash account has not been used within 365 days, the EBT system checks each individual cash benefit in the account to determine if it should be expunged. In order for an individual benefit to be expunged, the "available date" for that benefit must be at least 365 days in the past.
   b. KAMES sends the individual a notice after 12 months of inactivity to explain expungement. If the EBT card is not used after 365 days, a notice is sent advising the individual that they have not used their EBT account in the last 365 days and the benefits listed on the notice have been expunged from their EBT account. If the individual is deceased and the expunged amount is less than $25, a notice is not sent.
      1) The notice states that the individual cannot get these benefits back.
      2) If the individual owes any cash benefits on an established cash claim, these expunged benefits will be applied to that claim.

5. When cash benefits are expunged, KAMES updates the specific benefit segments with the amount expunged and the date. This information is available on the benefit inquiry screen.

6. If the case is inactive due to the only household member deceased, a notice will not be issued.

M. Access the EBT system at each reapplication to determine the status of an individual's EBT card. This prevents confusion when the applicant tries to access current benefits with a card that has been deactivated and allows recipients access to their benefits in a timely manner. Workers cannot assume that a card from an earlier eligibility period is still a valid card.

1. If the EBT card status is anything other than active (01) or inactive (00) or if the EBT card number is blank, do the following:

   a. Answer yes to the question "Does the household need a new EBT card?"; and
   b. Tell the recipient the old EBT card will not work.

2. The EBT account will always remain active on the EBT system. The EBT card will remain active unless reported as lost, stolen or damaged, or has otherwise been deactivated

N. Retailers have the right to request a debit to an individual's EBT account when it is discovered that the EBT transaction did not debit the account correctly.

When this occurs, KAMES will generate a notice to the individual advising that the EBT account will be adjusted to pay the retailer for the purchase.

If the individual contacts the local office worker and requests that the funds not be debited from the account and to request a fair hearing, send the individual's name, SSN, EBT account number, amount being debited, and the date the notice was sent to the individual by e-mail to the Division of Family Support, Attention Ricky May, Todd Trapp or Glenda Burke.

O. Screen changes to KAMES:

1. Issuance History Inquiry screen include adding:

   a. "Recon Number"
   b. "EBT indicator";
   c. "EBT amount expunged"; and
   d. "Date expunged by EBT.

2. Food Stamp benefits authorized representative identification is changed on KAMES EBT Information screen from "REPRESENTATIVE NAME" to "FS REPRESENTATIVE NAME".

3. KAMES Request EBT Card screen is changed to ask if the requested card is sent to the client or the local office.

P. Effective 12/1/07, individuals can use the benefits in the EBT account to repay an established K-TAP or Kinship Care claim. If the individual has sufficient benefits in the account, complete form EBT-6A, Cash Benefit Claims Repayment Request. Fax to the Claims Management Section (CMS) at 502-564-9810 upon completion of the form.

Volume I
The following manual sections are cross-referenced with this update: MS 0300, MS 0302, MS 0312, MS 0315, MS 0318, MS 0324, MS 0327, MS 1839 and MS1870
Volume II
The following manual sections are cross-referenced with this update: MS 8000, MS 8010, MS 8020, MS 8030, MS 8040, MS 8110, MS 8120, and MS 8210
Volume III
The following manual sections are cross-referenced with this update: ~~MS 2011~~, ~~MS 2201~~, and MS 5000
Volume X
The following manual section is cross-referenced with this update: OM Update No. 05-04, MS 99688 1/1/05.

MS 99769 PAFS-97 PROCESS AN ON-LINE FUNCTION OF KAMES

See OMTL-290, 4/1/08
See OMTL-294, 6/1/08
See OMTL-329, 4/1/09

As a result of an employee suggestion, effective October 1, 2007, form PAFS-97 is available on KAMES. This allows for statewide review of completed forms PAFS-97. The new screen allows workers to enter all the same data from the hardcopy PAFS-97 on the new online form PAFS-97. Workers are also able to inquire any form PAFS-97 previously entered after implementation date. Access is available from the KAMES Main Menu by selecting option "I", "PAFS-97 Add/Inquiry". This option takes the worker into a sub-menu to add a form PAFS-97, inquire a form PAFS-97, or update a form PAFS-97.

Starting October 1, 2007, workers must use the online form PAFS-97 unless the system is unavailable. If a hardcopy is used due to system unavailability, the information from the hardcopy must be entered online once the system becomes available.

A. To add a new form PAFS-97 online, select option "A", "ADD PAFS 97". When an "A" is entered on the sub-menu, the new online PAFS-97 screen appears. The online form mirrors the hardcopy form PAFS-97. The user is to enter information in each field. Once all data is entered, press enter to update information. Once form PAFS-97 is completed, it is automatically printed. The worker has the client sign the form, makes a copy for the file, and gives the original to the client.

B. To inquire a previously entered form PAFS-97, select function "B", "INQUIRE/UPDATE PAFS-97" on the sub-menu. When a "B" is entered on the sub-menu, a second sub-menu appears. Select the method of inquiry from the second sub-menu for any existing forms PAFS-97 by selecting one of the following:

   1. Social Security number;

   2. Complete name; or

   3. County.

   Once a selection is made, all forms PAFS-97 that were previously entered will display. To return to the sub-menu, press the F3 key. Hardcopy forms PAFS-97 will be kept in the local office to be used when KAMES is down. Otherwise, workers are to use the online form PAFS-97.

C. Workers will have the capability of updating a form PAFS-97 only the day it is initially entered. To update, select function "B", "INQUIRE/UPDATE PAFS-97", make the necessary changes, press enter to update information. Press F3 to return to the sub-menu.

Volume I
The following manual sections are cross-referenced with this update: MS 0095 and ~~MS 0150~~
Volume II
The following manual section is cross-referenced with this update: MS 6200
Volume III
The following manual section is cross-referenced with this update: ~~MS 2014~~
~~Volume IIIA~~
~~The following manual section is cross-referenced with this update:~~ ~~MS 4500~~
~~Volume IV~~
~~The following manual section is cross-referenced with this update:~~ ~~MS 2670~~
~~Volume IVA~~
~~The following manual sections are cross-referenced with this update:~~ ~~MS 4430~~ and ~~MS 4820~~
Volume VI
The following manual section is cross-referenced with this update: MS 4140

MS 99768 NEW DENIAL/DISCONTINUANCE REASONS

Effective October 1, 2007 local office staff will have a new reason code that will deny a pending regular food stamp application or discontinue a pending regular food stamp recertification so the applicant can apply for SAFE.

On the final FS disposition screen, for the question "TO DENY OR DISCONTINUE THE APPLICATION, ENTER APPROPRIATE CODE"; the worker can enter reason #6 which states "Opted out of regular food stamp for SAFE". When a pending application is denied with this reason code, the denial code is 269. If a pending recertification is discontinued with this reason code, the discontinuance code is 669.

Mark Washington, Commissioner

Volume II
The following manual sections are cross-referenced with this update: MS 3285
Volume X
The Table of Contents is revised to add OMU No. 07-19, MS 99768, 10/1/07

MS 99764 Death Matches

See Addendum To: OM Upd. No. 07-15, MS 99764, 6/4/07

In efforts to improve program efficiency and support fraud prevention, the date of death match process is expanded and improved effective 6/4/07. This applies to all programs.

Prior to this change, KAMES was producing date of death matches, but the system did not take action on the case. A spot check is posted for the worker to review the case and determine what action should be taken on the match.

Effective 6/4/07, the system takes action to automatically discontinue or deny benefits if a household member with a status of A, D, I, C or N shows a date of death match on the vital statistics database. KAMES matches all active social security numbers at application, reapplication, recertification, program transfer and member add. If a match is found, KAMES takes action to deny or discontinue benefits. The match will bypass any social security numbers that start with an 8 or a 9 as these are not actual social security numbers.

I. An initial match runs 6/4/07 to update current member information on KAMES. If a match is found, the following processing on KAMES occurs:

A. For food stamp cases:

1. If the match is on a case member, the member is removed.

2. If the match is on the head of household, the case discontinues for reason 523 (recipient deceased).

B. For K-TAP, Kinship Care and E&T cases:

1. If the match is on a case member other than the specified relative (SR), the member is removed from the case for reason code 723. If the member is the only active member in the case, the case discontinues for reason code 523.

2. If the match is on the case person (for example SR, Payee or someone coded as an M04 that is the case number), the case will discontinue for reason code 523, and alternate program, if applicable.

The deceased member may receive retro MA and MA coverage up through the month of death, if eligible.

C. For family related medical cases:

1. If the match is on a case member other than the SR, the member is removed from the case for reason code 723. If the member is the only active member in the case, the case discontinues for reason code 523.

2. If the match is on the SR, the case remains active in the deceased person's name if there is an eligible member in the case. A spot check is posted on the worker's DCSR to notify the worker that the case name needs to be changed. The Family Related case only discontinues if there are no remaining active members.

D. For adult medical cases the only member in an adult medical case is the recipient, therefore, the case discontinues for reason code 523 if a match is found.

E. A one-time match of all the active SSN's on the PA-62 system runs against the KAMES DOD database. These matches show on the report "PA-MATCH ON VITAL STATISTICS DATE OF DEATH" on RDS. Workers must take the appropriate action to discontinue these cases found on this report. There will not be a monthly match report for cases on the PA-62 system. Workers must continue to discontinue these cases when notified by the facility. When the cases are transferred to KAMES, the KAMES DOD database will match with the SSN's.

If the deceased member is the only active member in the case, the case discontinues, even if that member is not the head of household.

II. Effective 6/4/07, an on-line match occurs at application, reapplication, recertification, program transfer and member add.

If the match occurs on the head of household, KAMES displays a prompt which states "Person Deceased-Vital DOD MMDDCCYY" on the application/recertification menu screen. The worker can continue on with the application, reapplication, recertification, program transfer or member add and the system will take the following action:

A. For head of household (M03 or payee for K-TAP or Medicaid):

1. For food stamps, the application denies at disposition.

2. For K-TAP, the application denies or discontinues at disposition, or alternate program, if applicable.

3. For E&T cases, the case denies or discontinues at disposition or alternate program, if applicable. If the deceased individual is the only active member, the case discontinues even if that person is not the SR.

4. For family related MA, the case remains active in the deceased individual's name if there is an eligible member in the case. The worker receives a spot check notifying the worker that the case name must be changed. The spot check reads "VITALS DOD MMDDCCYY-REVIEW CASE". The family related MA case discontinues if there are no remaining active members.

5. For adult MA, at application, reapplication or program transfer the system allows eligibility for the period of time prior to death. For adult MA, at recertification, the case discontinues at disposition.

6. For Family and AFDC related Medical, if adding a deceased member, the member can be given retro MA through and including the month of death if all requirements are met.

B. For members, the worker receives the prompt "Person Deceased-Vital DOD MMDDCCYY" on the household member screen. The worker can continue and the case denies or discontinues benefits for that member at disposition.

For all IM cases, except adult MA, if the member being added is deceased, the member may get coverage for retro MA and MA up through the month of death.

C. For payments made on STEP:

1. STEP matches the client's SSN to the DOD database when a worker tries to make a WIN payment from Option E, Payments. If there is a match, the message "Person Deceased – Vital Statistics Match - Cannot Issue Payments" displays. No payments can be made. No DOD match is completed for the initial WIN payment automatically issued by STEP.

2. STEP matches the DOD database before payments are issued from Option G, Monthly Tracking. Once the worker enters monthly tracking, STEP processes the tracking information and a DOD match is completed before the transportation payment is auto issued. If there is a match, the transportation payment is not issued and the message "Person Deceased – Vital Statistics Match – Cannot Issue Payments" displays on the STEP Main Menu screen.

3. A DOD match is completed anytime the worker tries to make a supportive services or car repair payment from Option E, Payments. If there is a match, the worker cannot make the payment and the message "Person Deceased – Vital Statistics Match – Cannot Issue Payments" displays. If the payment is appropriate, send a request for payment to the Family Self-Sufficiency Branch (FSSB) through the Regional Office.

D. For FAD cases, the DOD match is done at case level and member level.

1. When Option A, Process Payment, is selected on the Family Alternatives screen, the DOD match is completed on the case number. If there is a match, the message "Person Deceased – Vital Statistics Match" displays. No payments can be issued for case.

2. If the there is no match at case level, a DOD match is completed for each member SSN entered on the FAD Member Update screen. If a match is found, each matched SSN is highlighted one at a time, and the message "Person Deceased – Vital Statistics Match" displays.

   a. If the only member in the household, coded M05, is matched, a payment cannot be issued and the message "Person Deceased – Vital Statistics Match – Case Ineligible" displays.

b. If there are multiple members coded M05 and at least one is not matched, the worker can make the FAD payment. The message "Person Deceased – Vital Statistics Match – Press Enter To Cont." displays.

3. At the supervisor approval process, the DOD match is completed again to ensure a match does not exist prior to the supervisor approval.

   a. If a match exists, the message "Member is Deceased – Vital Statistics Match – Delete Payment" displays and the FAD payments do not approve. Only a "D" can be entered to delete the payments. If any thing else is entered, the message "Invalid Entry" displays.
   b. If no match is found, the payments can be approved.
   c. If there is a match, but the payment is valid, sent a request for payment to FSSB through the Regional Office.

III. KAMES runs a monthly match on the 12th day of the month (or prior workday if the 12th is a weekend of holiday). The case processing is the same as the initial match.

Mark Washington, Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 1941
Volume X
The Table of Contents is revised to add OM Upd. No. 07-15, MS 99764, 6/4/07.

MS 99764 Death Matches

OM Update No. 07-15, MS 99764, Death Matches, was issued informing field staff that KAMES would begin taking action effective 6/4/07 to automatically discontinue or deny benefits if a household member showed a date of death match on the vital statistics database. This change was initiated in an effort to improve program efficiency and support fraud prevention. The matches were based only on social security numbers at application, reapplication, recertification, program transfer and member add. All programs were affected by this change.

Field staff were notified by a News Message, "Death Match", on 6/4/07 – 6/5/07 that there were cases incorrectly matched against the vital statistics death match. Instructions were outlined in the News Message on how to correct these erroneous matches.

Changes have been implemented in KAMES to minimize erroneous discontinuances in the future. Effective 7/2/07, date of death matches are based not only on social security number but also on the first five (5) characters of the last name and the initial of the first name.

This update is issued to inform field staff of the procedures for any future erroneous matches.

A. If a member is removed and the case remains active:

1. Complete a member-add for the member that Vital Statistics is showing as deceased allowing the system to assign a pseudo number;
2. Answer "N" to SSN/Name matches with the member's real SSN;
3. Advise the client to notify Vital Statistics, 275 E. Main St., 1E-A, Frankfort, KY 40621, (502) 564-4212, concerning the invalid date of death information;
4. Set up a manual spot check to review the "Vital Statistics Death Information" option Q, KAMES Inquiry Menu, for the member's SSN in 30 days to determine if Vital Statistics has corrected their information. The IM spot check reason code is "89". The FS spot check reason code is "0".
5. If the member is no longer identified as being deceased after 30 days, move the member (pseudo SSN) out;
6. For IM cases: Complete a member-add for the member using their real SSN in the month following the month that the member was removed with their pseudo number;
7. For FS cases and K-TAP cases: Complete a member-add for the member with their real SSN if the member (pseudo SSN) was moved out prior to cut-off. Answer the question that the member has received benefits for the current month. If the member (pseudo SSN) was moved out after cut-off, wait until the following month and enter the member-add and answer that the member has received benefits for the current month;

8. When adding the member back using their real SSN, answer “Y” to the SSN/Name matches with the member’s real SSN and “N” for the matches with the pseudo SSN.

B. If the Head of Household is removed and the case is inactive:

1. Enter a new application allowing the system to assign a pseudo number
   a. IM cases – enter the reapplication: If the case was discontinued after cut-off, the reapplication should be entered the next administratively feasible month.
   b. FS cases – enter the reapplication:
      (1) If the case was discontinued prior to cut-off, enter the reapplication the same month as discontinuance and answer “Y” to the question “Received FS benefits this month?”.
      (2) If the case was discontinued after cut-off, enter the reapplication the month following the discontinuance month and answer “Y” to the question “Received FS benefits this month?”.
2. Answer “N” to SSN/Name matches with the member’s real SSN;
3. Enter members not identified as deceased with their real SSNs;
4. Advise the client to notify Vital Statistics concerning the invalid date of death information;
5. Set up a manual spot check to review the “Vital Statistics Death Information” Inquiry for the member’s SSN in 30 days to determine if Vital Statistics has corrected their information;
6. After checking “Vital Statistics Death Information” Inquiry, if the member is no longer identified as being deceased, discontinue the pseudo SSN case;
7. Reapp the case in the real SSN:
   a. IM cases – enter the reapplication:
      (1) If the case was discontinued prior to cut-off, enter the reapplication the following month;
      (2) If the case was discontinued after cut-off, enter the reapplication the next administratively feasible month.
   b. FS cases – enter the reapplication:
      (1) If the case was discontinued prior to cut-off, enter the reapplication the same month as discontinuance and the answer “Y” to the question “Received FS benefits this month?”;
      (2) If the case was discontinued after cut-off, enter the reapplication the month following the discontinuance month and answer “Y” to the question “Received FS benefits this month?”.
8. When reapping the case in the real SSN, answer “Y” to the SSN/Name matches with the member’s real SSN and “N” to the matches with the pseudo SSN.

C. If the Head of Household is removed and the case is active (Related MA cases):

1. Discontinue the case in the “deceased” person’s SSN;
2. Follow instructions B. #1 - #8 for “Head of Household removed, case is inactive”.

D. If taking a new application or reapplication:

1. Matches to the head of household;
   a. Enter the application with a pseudo SSN;
   b. Answer “N” to SSN/Name matches with the member’s real SSN;
   c. Answer “already received” questions as appropriate;
   d. Follow “Head of Household removed – case is inactive” instructions B. #3 – #8 above.
2. Matches to non-Head of Household;
   a. Move the member out;
   b. Enter the member with a pseudo SSN;
   c. Answer “N” to SSN/Name matches with the member’s real SSN;
   d. Answer “already received” questions as appropriate;
   e. Follow “Member removed – case is active” instructions A. #3 – #8 above.

Mark Washington, Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 1941
Volume X
The following manual section is cross-referenced with this update: OM Upd. No. 07-15, MS 99764, 6/4/07.

MS 99762 WORK-ELIGIBLE INDIVIDUALS

See OMTL-329, 4/1/09
See OMTL-302, 7/1/08
See Errata To: OM Upd. No. 07-13, MS 99762, 5/1/07

With reauthorization the term "work-eligible individual" was established, which is used to define those individuals who are included in the denominator of the work participation rate calculation.

A. This resulted in the following changes in K-TAP policy:

1. Individuals who provide medical documentation that they must provide constant care for more than 8 consecutive weeks for a disabled family member who lives in the home and does not attend school on a full-time basis may be exempted from participation. Individuals who qualify for this exemption are removed from the denominator.

2. Individuals disqualified as fleeing felons or drug felons are now included in the participation rate and are required to participate in the Kentucky Works Program (KWP). These individuals are now included in the denominator when calculating the participation rate.

B. Upon implementation, system support was not available to accommodate these changes. Effective May 1, 2007 system support will be in place to accommodate these changes as follows:

1. A new exemption code of "D" is created to use for individuals who provide form PA-4, Statement of Required Caretaker Services, that verifies he/she must provide constant care for more than 8 consecutive weeks for a disabled family member. For more information, refer to OM Update No. 06-24, Work Eligible Individuals for the Kentucky Works Program (KWP), MS 99743, 10/1/06.

   A tickler file of cases for which an exemption code change is needed was to be maintained. The tickler file must be reviewed. Individuals who meet the exemption criteria must have the new "D" code entered on KAMES. The review of the tickler file and the addition of the exemption are to be done immediately as these individuals are counting in the denominator and reducing your KWP participation rate. Please retain your tickler file to be used to potentially adjust the denominator for months prior to June 2007. Additional information will be provided on identifying these individuals back to October, 2006.

2. KAMES will create a record on STEP for disqualified drug and fleeing felons. Check your listing to determine whether any individuals affected by this change are now showing as mandatory KWP participants. Assess as soon as possible as they now count in the calculation of the participation rate. These individuals are subject to the same KWP policy and procedures as other KWP participants.

These individuals are required to complete an assessment, participate in KWP and are subject to sanction. As these individuals are now required to participate, they may also be eligible for supportive services. Existing KWP policy and procedures apply to these individuals.

Mark Washington, Commissioner

Volume III
The following manual sections are cross-referenced with this update: MS 2003, ~~MS 2322~~, ~~MS 2324~~ and ~~MS 2325~~
Volume IIIA
The following manual sections are cross-referenced with this update: ~~MS 4000~~, ~~MS 4600~~, MS 4720 and ~~MS 4750~~

MS 99762 WORK-ELIGIBLE INDIVIDUALS

See OMTL-329, 4/1/09
See OMTL-302, 7/1/08

Following issuance of OMU 07-13, we received a clarification from the Department of Health and Human Services, Administration for Children and Families (ACF) that impacts the definition of work-eligible individuals.

ACF states that only a parent can be exempt from Kentucky Works Program (KWP) participation due to caring for a disabled family member. This means that a nonresponsible specified relative included in the K-TAP case and required to participate in KWP cannot be exempted from KWP due to caring for a disabled family member.

When reviewing the tickler file, remember to check the relationship of the individual. The "D" exemption code can only be entered for a parent. A nonresponsible specified relative who is included in the case is not exempt for this reason and is subject to participation requirements.

Example: A sibling has a K-TAP case for 3 sisters. One of the younger sisters is disabled and requires constant care. The older sibling who is coded as M03 cannot be exempted from KWP using the "D" code.

We are in the process of getting a listing of the individuals who were coded with a "D" good cause reason in April. The listing and instructions for its use will come under a separate memo very soon.

Mark Washington, Commissioner

Volume III
The following manual sections are cross-referenced with this update: MS 2003, ~~MS 2322~~, ~~MS 2324~~ and ~~MS 2325~~
Volume IIIA
The following manual sections are cross-referenced with this update: ~~MS 4000~~, ~~MS 4600~~, MS 4720 and ~~MS 4750~~
Volume X
The following manual sections are cross-referenced with this update: OM Upd. No. 07-13, MS 99762, 5/1/07

MS 99761 RESPONSE TO QUALITY CONTROL ERRORS

Quality Control (QC) reviews have always included related observations on PAFS-343, Quality Control Review Memo. In the past, it was not necessary to advise what action was taken to address the related observations on form PAFS-343.1, Response to Quality Control Errors. Effective 5/1/07, form PAFS-343.1 is to be completed on agency/recipient errors and related observations.

Mark Washington, Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 0506

MS 99760 WEP/COM POLICY CHANGES

See OMTL-329, 4/1/09

This update is issued to change policy regarding the 12-month time limit on Work Experience Training Program (WEP) and Community Service Program (COM) activities.

A. Effective May 1, 2007, WEP/COM placements no longer have a 12-month lifetime limit for participants.

WEP worksite agreements are written for no more than six months per placement. However, a participant is no longer limited to one 6-month placement per provider.

This change is to assist Kentucky Works Program (KWP) participants in meeting participation requirements while ensuring placements remain beneficial to participants. The flexibility of additional time in WEP/COM placements provides an extended learning tool for participants to gain skills and confidence needed for employment.

B. All WEP/COM placements are reviewed at the end of the six-month agreement by the case manager to:

1. Determine if the participant is progressing toward a specific skill;
2. Ensure the placement will continue to be beneficial to the participant;
3. Determine if the placement continues to meet KWP participation requirements; and
4. Assess whether WEP/COM placement for an additional six months is appropriate for the participant.

C. If it is determined that the WEP placement is to be continued, form KW-244, WEP Training Site Agreement Amendment, is completed indicating the change in the agreement period and adding any additional skills to be pursued.

D. A listing of participants in their 6th month of WEP/COM placement will be made available on RDS and DocumentDirect. This listing is utilized by the case manager to ensure that all 6-month WEP/COM placements are identified and reviewed for potential continuation.

E. The listing must be reviewed by the supervisor to ensure the criteria in item B.4. remains valid for the placements continued by the case manager. The listing must be annotated by the supervisor and forwarded monthly to a designated individual in each regional office. The designated individual reviews the listing to ensure that the placements remain valid and of benefit to the participant. Periodically, the Family Self-Sufficiency Branch will request these listings to review WEP/COM placements for each region.

F. Staff continue to follow procedures outlined in the Division of Family Support Operation Manual, Volume IIIA, MS 4230, 4270 and 4280 for other policy regarding WEP/COM placements.

Staff are reminded to monitor WEP/COM placements continually throughout the placement period and to update STEP comments and the Transitional Assistance Agreement (TAA) with any changes. If at any point in time the WEP/COM placement is determined not to be beneficial to the participant, the placement is terminated and a different placement or component activity is found that will benefit the participant.

Mark Washington, Commissioner

Volume IIIA
The following manual sections are cross-referenced with this update: ~~MS 4230~~, ~~MS 4270~~ and MS 4280

MS 99758 KAAAP CASE SUMMARY SCREEN

Effective 4/9/07, a new inquiry screen, Case Summary, will be displayed on the KAMES Case/Pending Inquiry Menu for all programs. The new screen will display a summary of case and member information for all household members, with the exception of "T" members, in the case. This change is the result of a "Quick Win" identified during the Kentucky Access, Accuracy and Accountability Project (KAAAP) sessions.

The Case Summary will display on one screen and contain the following information. (If more than 5 household members, a second screen will contain the additional members):

- Case Number;
- Program Code;
- Case Status Code;
- Case Reason Code;
- Effective Date ;
- Caseload Code;
- Caseworker Code;
- Approval ID;
- Cert Begin Date;
- Cert End Date;
- TMA Start Date;
- TMA End Date;
- Premiums (Y/N);
- Premium Start Date;
- County Code;
- Home Address;
- Mail Address;
- Authorized Representative;
- Authorized Representative SSN;
- Authorized Representative Type;
- K-TAP Benefits (Only regular payments, retro payments and prorated payments will be displayed. Supplemental payments and special payments will not be displayed.);
- MA only cases will not display a benefit amount. (The benefit month field will be blank. The entitled amount, issued amount and the reduced amount fields will contain one zero);
- FS Benefits;
- Case Unearned Income;
- Case Earned Income;
- Case Total Gross Income;
- Case Resources;
- Case Medical Deductions;
- Case Dependent Care;
- Case Shelter;
- Case Utility Expense;
- Case Shelter Deduction;
- Member Name;

- Member SSN;
- Member Date of Birth;
- Member Earned Income;
- Member Unearned Income;
- Member Self-Employment Income;
- Member Resources;
- Member Medical Expenses; and
- Member Child Care Expenses (An indicator will be displayed that this person is responsible for paying child care.)

To access the new Case Summary inquiry screen and display the above information:

- Go to the KAMES Case/Pending Inquiry Menu;
- Enter the case number;
- Enter "1" in the "Segment" field; then press enter.

Pages #1 and #2 will display up to 20 case members. Pressing enter will navigate the user between screens #1 and #2. If it is necessary to access additional members (page 2), and history is needed, do NOT key PF8/20 from page #2:

- Press "enter" to return to page #1;
- Press "PF8/20" to the appropriate history period; then
- Press "enter" to see the additional members for that period.

To access member information:

- Enter "S" (select) for the member;
- Enter "X" next to the specific income/deduction to be viewed (only one type can be selected);
- Press "enter" to see the specific income/deduction.

After viewing a specific member's income/deduction, press PF4/16 to return to the Case Summary inquiry screen.

The purpose of this change is to save staff time in accessing this information.

Mark Washington, Commissioner

Volume VI
The following manual section is cross-referenced with this update: MS 1400

MS 99748 TIMEFRAME FOR ENTERING POTENTIAL CLAIMS ON KCD

Form PAFS-431, Claim Referral, is completed upon discovery of a potential claim.

Effective with this policy update, the worker must do the following within 10 days of the discovery date:

- Enter the potential claim on KCD; and
- Generate an appointment letter to the household.

Tom Emberton, Jr., Commissioner

Volume I
The following manual sections are cross-referenced with this update: MS 1545, MS 1555, MS 1575, MS 1672 and MS 1809

MS 99745 COUNTING, VERIFYING AND DOCUMENTING HOURS OF KWP PARTICIPATION

See OMTL-329, 4/1/09
See Errata to OM Upd. No. 06-26, MS 99745, 10/1/06

The Deficit Reduction Act (DRA) of 2005 was signed on February 8, 2006 reauthorizing the Temporary Assistance for Needy Families (TANF) program known as the Kentucky Transitional Assistance Program (K-TAP) in Kentucky.

On June 29th, 2006 the Department of Health and Human Services (HHS) issued regulations regarding the reauthorization of the TANF program. These regulations provide changes in how hours are counted and program participation is verified and documented.

The procedures used to calculate hours of participation in the Kentucky Works Program (KWP) are changed. The changes include: which hours are counted; how hours are calculated for certain activities; at what frequency the hours are verified and the types of supporting documents used to verify the countable hours of participation for KWP individuals. Count only actual or deemed hours of participation toward the required hours.

A. Effective October 1, 2006, use the following formulas to calculate the number of countable hours for KWP individuals participating in self-employment, a work experience program (WEP), or a community service program (COM).

1. For self-employed participants, divide the individual's self-employment income (gross income less expenses) by the number of months to be considered, and then divide the result by the Federal minimum wage ($5.15). The resulting number is the monthly hours countable towards participation. Round the resulting monthly hours to get a whole number.

$$\text{Monthly Hours} = \frac{\text{Gross income – expenses}}{\text{Federal minimum wage ($5.15)}}$$

The following number of hours are needed per month to consider a self-employed individual as meeting participation requirements for the month, based on the formula above:

a. 87 for an individual required to do 20 hours a week;
b. 130 for an individual required to do 30 hours a week;
c. 152 for a household required to do 35 hours a week; and
d. 238 for a household required to do 55 hours a week.

If computed monthly self-employed hours are less than participation requirements, use the following formula to figure countable weekly hours:

Monthly hours/4.3 = weekly countable hours

Example: An individual is required to participate 30 hours a week in KWP. He/she has calculated self-employment hours of 85 per month. 85/4.3 = 19.77; therefore, this participant can count self-employment for 20 hours a week towards participation and must participate in another activity for 10 hours to meet participation requirements.

This calculation of hours applies to all individuals who state they are self-employed even if they state they charge an hourly rate. In order for a participant to be considered participating the correct number of hours according to the self-employment calculation, enter the resulting number of monthly hours on KAMES based on the above formula.

2. WEP and COM participants are considered as employees under the guidelines set by the Fair Labor Standards Act (FLSA). This means states cannot require welfare recipients to work/participate in these programs more hours than he/she is compensated by the K-TAP grant amount. The K-TAP grant is divided by Federal minimum wage ($5.15). The resulting number is the monthly countable hours allowed under WEP or COM. When computing the monthly countable hours only use the K-TAP amount actually issued to the household, and not the amount in which the household may be eligible.

   HHS realized with the new stipulation, dictating that KWP participants can only participate in WEP or COM so many hours based on their grant amount and minimum wage, it would be almost impossible for participants in many states to meet participation requirements in these two components. Therefore, the Federal government allowed states to request participation in a mini-simplified Food Stamp program. A mini-simplified Food Stamp program allows states to add the Food Stamp (FS) allotment to the K-TAP grant amount when figuring the monthly hours a participant in WEP or COM can participate. Kentucky is approved for the mini-simplified Food Stamp program. The use of the FS allotment in calculating hours of KWP participation does not affect the FS case in any way.

   a. Use the following formula to determine the number of countable hours for a recipient participating in WEP/COM. If a K-TAP household receives Food Stamps then the total FS benefits issued for the household is added to the K-TAP grant amount and then divided by $5.15 to figure the countable hours of participation.

      $$\text{Monthly Hours} = \frac{\text{K-TAP grant amount + Food Stamp allotment}}{\$5.15}$$

      1) Example: K-TAP case consists of mom and one SSI child. K-TAP mom and SSI child are included in a FS case with her parents and 2 siblings, with FS benefits totaling $648.00. Take the total FS allotment ($648.00) added to the K-TAP grant amount ($186.00) and then divide by $5.15 to get the number of monthly hours countable towards participation. To figure weekly hours, divide the monthly hours by 4.3. Do not round until the end of the weekly hours calculation.

$186.00 + $648.00 = $834.00/$5.15 = 161.94 (monthly hours)
161.94/4.3 = 37.66 weekly hours. Since hours exceed the participants 30 hour requirement, the requirement may be fully met by participation in WEP or COM.

2) Example: A K-TAP case receiving a grant amount of $383.00 consists of mom, dad and 4 children, who receive federally funded child care. The FS case includes the same 6 household members with benefits totaling $596.00.

$383.00 + $596.00 = $979.00/$5.15 = 190.10 (monthly hours)
190.10/4.3 = 44.21, this equals 44 weekly countable hours.

Adding the FS allotment allows the state to deem a KWP participant as meeting the core hours, even if the computed hours do not equal the required core hours (20 for all "C" cases and 30 for "W" cases or 50 for "W" cases receiving federally funded child care).

In example a.2. above, one K-TAP unemployed parent would be required to participate 44 hours a week in WEP or COM, but it would count for 50 hours. Then the same parent or the other parent would have to participate in another countable activity for 5 hours to meet participation requirements. However, if the monthly computed hours equals or exceeds the total required hours for monthly participation, then the individual does not have to engage in another activity.

When there is an on-going change in either the Food Stamp allotment or the K-TAP grant, monthly hours must be recalculated. The inclusion of FS in this calculation and deeming of hours only applies to those who are participating in WEP or COM.

b. If a K-TAP household does not receive FS benefits, then only the K-TAP grant amount may be used in the calculation when determining hours of participation. If the calculated hours using only the K-TAP grant amount, are less than the required core hours of 20/30/50, the participant cannot be deemed as meeting.

1) Example: K-TAP case consists of mom and child. Monthly K-TAP benefits are $225.00. Mom is only 21 and lives with her parents and cannot receive FS benefits because her parents must be included on the FS case. The parent's combined income exceeds the income limits allowed for a household size of 4 to receive FS benefits. Calculate the weekly hours this client can participate in WEP or COM as follows:

$225.00/$5.15 = 43.69 (monthly hours)
43.69/4.3 = 10.16 weekly hours.

In this example the client can only participate in WEP or COM for 10 hours a week. Ten hours are counted toward her total required hours of participation.

2) Example: Mom is participating in vocational education for 20 hours but is required to meet the 30 hour participation requirement. Mom may participate in WEP or COM provided the calculated hours equal 10 or more which will allow her to meet the 30 hour requirement.

If a participant does not receive FS benefits, the case manager should only encourage participation in WEP or COM when additional hours are needed to meet hourly participation requirements.

B. Federal regulations allow states, in certain circumstances, to count excused absences when a participant was scheduled to participate on that day.

1. Employed individuals who miss work on a scheduled work day due to sickness or who are granted paid leave, either sick or holiday pay for that day are considered participating for that day.

2. In all other countable activities, states may now grant KWP participants an excused absence when a scheduled day of participation is missed, for the following reasons:

   a. Sickness;
   b. Job interview;
   c. Doctor appointments for self or child;
   d. Court appearances;
   e. School meeting or functions for child;
   f. Death of a family member;
   g. Life changing event (such as marriage, divorce, etc.); or
   h. Family emergency.

   A participant is allowed up to 2 excused absences per month; not to exceed 10 in a 12 month period. Acknowledged holidays taken by the service provider are not part of the 10 excused absences; holidays are allowed in addition to the 10 excused absences. An example of a holiday would be factory shutdown or school closing, such as fall, Christmas or spring break. An excused absence covers the number of hours the individual is scheduled to participate on that day. If an individual misses only a partial day, this still counts as one of the 10 excused absences.

   In order to count and grant an excused absence for one of the above reasons, the participant must call both the case manager and service provider and provide proper verification of an excused absence to the case manager within 7 days of the missed day. The verification needs to be an official document or signed by someone other than the client or family member, except, on rare occasions (e.g. written statement from the employer, doctor's note, court date letter, marriage certificate). Once the verification is provided, the participant is not required to make up the missed hours and the hours are counted when determining if the participant met the monthly participation requirements.

C. The new Federal guidelines governing how often hours of participation must be documented result in a change regarding how often participation is verified and what documentation is used to verify actual hours of participation. Workers must request and receive the documentation as deemed necessary to ensure participants are meeting mandatory KWP requirements.

1. Subsidized or unsubsidized employed individuals, including self-employed, wage subsidy or on the job training (OJT) participants, must verify weekly hours worked a minimum of every 6 months. However, if the individual experiences a permanent change in hours such as a decrease or an increase, the individual must report the change and verify the new hours.

   Pay stubs, time and attendance records, employer reports, or for self-employment, copies of customer receipts may be used to verify a participant's hours (e.g. completed PAFS-700 or written statement).

   Self-employment can no longer be verified by self-prepared client records, except for a self-prepared tax return. However, if clients give receipts to each person he/she provides a service to and has that individual initial and date the copy retained in the client's records, then this type of record may be used as verification. This holds true for invoices as well, if the invoices list exact items and are either original store receipts or a receipt from an individually owned store that is signed and dated by the store employee at the time of purchase.

2. All non-employment activities must be supervised and attendance recorded daily.

   a. Service provider attendance records, sign-in sheets, or time sheets may be used to verify hours of participation for the following activities:
      1) WEP;
      2) COM;
      3) Job search and job readiness assistance (JRA);
      4) Short-term training (STT);
      5) Providing child care assistance to a KWP participant in a COM;
      6) Job skills training directly related to employment;
      7) Education related to employment; or
      8) Satisfactory attendance at secondary school.

   b. School records or written statements from teachers may verify participation in a secondary school activity.

   c. For vocational educational training, each student verifying actual classroom hours can maintain a monthly calendar sheet for each class and have the professor initial the appropriate day after class. The hours of participation must be verified to the case manager no less than monthly for all non-employment activities.

      Additionally, only weekly/monthly study hours that are monitored and verified by a facilitator can be considered as part of his/her countable hours.

d. All actual hours used to meet participation requirements for all countable activities must be monitored and documented. The exception is employment which may be projected out 6 months based on documentation of hours of work submitted by the client. This documentation is submitted along with form PA-33, Verification of Transportation and Participation in Education or Training Activity, each month. Examples of methods providers may use to track and document hours are:

1) A monthly calendar sheet for each individual with the number of actual hours for each appropriate day signed at the bottom of the sheet; or
2) A sheet of paper that list the individual's name, each day he/she attended the activity, the number of hours, and is signed by the person monitoring the individual.

D. KWP participants involved in any educational component, both core and non-core, are required to maintain good or satisfactory progress in order for their hours to count. Overall program progress is determined by a standard developed by the educational institution or program in which the participant is involved. This standard needs to be used by the worker to decide if a participant is making good or satisfactory progress within the program.

Progress can be verified by the school through such items as grade reports, written statement from the institution, or statement from the school counselor. For those attending secondary school, participants are to verify progress every time grades are distributed to the student. For those participating in a vocational education program, participants are to verify progress at the end of each semester or what would be equivalent to a semester if a semester system is not used.

Tom Emberton, Jr., Commissioner

Volume III
The following manual sections are cross-referenced with this update: MS 2715 and MS 2770
Volume IIIA
The following manual sections are cross-referenced with this update: ~~MS 4210~~ MS 4220, ~~MS 4230~~, MS 4260, ~~MS 4270~~, MS 4280, MS 4650, and MS 4800

MS 99745 COUNTING, VERIFYING AND DOCUMENTING HOURS OF KWP PARTICIPATION

See OMTL-329, 4/1/09

This Errata is being issued to clarify policy concerning the entering of self-employment hours.

OM Update No. 06-26, MS 99745, A.1, last paragraph states to enter the monthly hours based on the calculation formula. This is incorrect; workers need to figure monthly hours to insure the client is meeting KWP participation. However, once monthly hours are figured, the monthly hours are converted to weekly hours by dividing monthly hours by 4.3. The weekly hour figure is entered on KAMES on the self-employment screen under "Hours worked each week".

Tom Emberton, Jr., Commissioner

VOLUME III
The following manual sections are cross-referenced with this update: MS 2715 and MS 2770
VOLUME IIIA
The following manual sections are cross-referenced with this update: ~~MS 4210~~, MS 4220~~,~~ ~~MS4230~~, MS4260~~,~~ ~~MS 4270~~, MS 4280, MS 4650, and MS 4800
Volume X The following manual section is cross-referenced with this update: OM Upd. No. 06-26, MS 99745, 10/1/06

MS 99743

WORK-ELIGIBLE INDIVIDUALS FOR THE KENTUCKY WORKS PROGRAM (KWP)

See OMTL-329, 4/1/09

With the enactment of the Deficit Reduction Act (DRA) of 2005, which reauthorized the Temporary Assistance for Needy Families (TANF) program, there is a new term for individuals who are required to participate in KWP. The term "work-eligible individual" prescribes the individuals who are included in the work participation rate calculation.

A. Work-eligible individuals include:

1. A minor parent coded as M03, M04 or an adult who is included in the Kentucky Transitional Assistance Program (K-TAP) benefit group as an active member unless he/she is exempt for one of the reasons in item B. Nonresponsible specified relatives not included in the case (child only case) are not subject to KWP.

2. A parent who is living with the child but not included in the K-TAP benefit group as an active member.

   Example: Parents who are disqualified from receiving K-TAP (e.g., due to a drug felony conviction, who is a fleeing felon or probation/parole violator, etc.) are considered work-eligible individuals and must now participate in KWP. If they do not participate, they are subject to KWP penalties.

   KAMES staff is working to have these individuals transfer to STEP. Another policy update will be issued at the time of production to discuss the payment of supportive services for these individuals and how to apply the KWP penalty when appropriate.

3. The following are not considered work-eligible individuals and are not required to participate in KWP:

   a. A minor parent who is not the head of household or spouse of the head of household;

   b. An alien who is ineligible to receive K-TAP due to his/her alien status; and

   c. An SSI recipient.

B. The DRA established a new reason that can exempt a work-eligible individual from KWP participation as well as retaining the original two reasons. The three exemptions are:

1. A work-eligible individual caring for a child under the age of 12 months. The individual can be exempted for up to 12 cumulative months in a lifetime;

2. A teen parent, up to age 18 years, with a child under 12 weeks old;

3. A work-eligible individual expecting to provide constant care for more than 8 consecutive weeks for a disabled family member living in the home who does not attend school full-time.

   a. Disabled is defined as a mental or physical impairment that substantially limits the capacity to adequately perform one or more activities of daily living, such as mobility, communication, self-care, self-direction, inter-personal skills, work tolerance or work skills.

   b. Constant care is defined as active care for the disabled family member living in the home by a work-eligible individual other than the time the disabled family member sleeps. Constant care is not considered if the disabled family member attends full-time school or other program or activity outside the home unaccompanied by the work eligible individual.

   c. Family member is an individual who is related by blood, marriage or adoption.

   Verify relationship of the family member to the individual using sources listed in VOL. III MS 2329.

C. With the new exemption reason, caring for a disabled family member, the good cause reasons for caring for a mentally or physically disabled family member is revised. Now, if the work-eligible individual is providing constant care for less than 8 consecutive weeks for a disabled family member, who lives in the home and is not in full-time school attendance, good cause may be granted. If the care is needed for 8 consecutive or more weeks, refer to item B.

D. The reason for the extension of K-TAP benefits past the 60-month lifetime limit is revised to state if a work-eligible individual is providing constant care for a disabled family member who is living in the home and not in full-time school attendance. Workers will continue to use extension Code C when granting an extension for this reason.

E. The exemption, good cause and extension reasons of caring for a family member are verified by form PA-4 (revised 10/06), Statement of Required Caretaker Services. Individuals receiving an exemption or an extension for this reason must be reviewed every 6 months and a new form PA-4 completed at the review.

   If good cause is granted and at the end of 8 consecutive weeks the work-eligible individual still claims good cause, obtain a new form PA-4 to determine if the exemption is appropriate.

F. Take the following actions to implement the new policy:

1. Review KWP cases granted good cause for caring for a disabled family member to determine if any of them meet the new exemption criteria in item B;

2. For any case which meets the new exemption criteria, have form PA-4 completed to verify the need for constant care; and

3. KAMES staff is developing a code for the new exemption reason. When the new code is in production field staff will be notified to enter the code. In the interim, when a completed form PA-4 is received, annotate KAMES comments and maintain a tickler file of the cases for which an exemption code change is needed.

Tom Emberton, Jr., Commissioner

Volume III
The following manual sections are cross-referenced with this update: MS 2003, ~~MS 2322~~, ~~MS 2324~~ and ~~MS 2325~~.
Volume IIIA
The following manual sections are cross-referenced with this update: ~~MS 4000~~, ~~MS 4600~~ and MS 4720.

MS 99742 IMPLEMENTATION OF THE RANDOM MOMENT SAMPLING SYSTEM

Effective 9/16/06, a Random Moment Sampling (RMS) system begins for Family Support field staff. RMS is used to determine the distribution of staff and overhead costs for the various programs and services administered by the Department for Community Based Services.

A. The pool of Family Support workers used in the sample are those workers directly involved in day-to-day frontline eligibility determinations for program assistance and services. Family Support positions affected by RMS are:

1. Case Management Specialist I, II and III; and

2. Family Support Specialist I, II and III.

B. The sample of 1,000 random moments is created from a pool of Family Support workers and available minutes in the sampling month.

C. RMS is completed by the immediate supervisor of the workers included in the sampling. The supervisor is the “observer” for RMS purposes. The supervisor designates a backup for instances when he/she is unavailable to observe a worker for a particular random moment.

D. The procedures for RMS are:

1. The observer asks the worker to describe the activity that he/she is doing at the identified moment.

2. The worker provides a complete description of the activity including a case number, if applicable.

3. The observer asks questions, if needed.

4. The observer records the necessary information on form RMS-1.

5. The worker initials and records the actual time and date he/she was observed.

E. If a worker will be working outside the office, the worker must complete form RMS-4A, Random Moment Sampling Recall, to record any activities or work performed for the time spent outside the office.

F. When a worker, who is identified in the RMS sampling, is working outside the office during the random moment:

1. The observer leaves form RMS-4, Random Moment Sampling Form, on the worker’s desk annotated with the time and date of the random moment.

2. After the worker returns to the office and within one work day, the worker:

a. Records on form RMS-4 the description of the activity for the identified random moment. The worker refers to form RMS-4A for this information;

b. Lists the case number, if applicable;

c. Enters the time and date the form is completed and initials the form; and

d. Attaches form RMS-4A to form RMS-4 and returns them to the observer.

3. If the worker will not return to the office within one workday, the observer may contact the worker by telephone to obtain the information. If the observer is unable to contact the worker, the random moment is considered as a missed hit.

G. With the implementation of RMS, staff will no longer complete form P-4S, Timesheet Addendum for Detailed Program Code Documentation. Workers continue to complete their timesheets using the existing program function codes.

As the information gathered by RMS is used to determine staffing and distribution of program funds, it is very important that the worker cooperate and provide accurate information about the activity performed in the identified random moment.

Tom Emberton, Jr., Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 0180
Volume X
The following manual section is crossed-referenced with this update: OM Upd. No. 01-05, MS 99553, 5/1/01

MS 99740 EXTENSION REASONS FOR INCAPACITATED WORK-ELIGIBLE INDIVIDUALS

Effective October 1, 2006, the extension reason due to incapacity is changed for two-parent families receiving assistance in the Kentucky Transitional Assistance Program (K-TAP). The extension reason due to incapacity for a one-parent family is not changed.

A. Households with two-parents are no longer considered eligible for an extension of the 60-month lifetime limit for K-TAP unless both parents have an extension reason. Therefore, consideration for an extension for a two-parent family with a deprivation of incapacity is placed on the non-incapacitated work-eligible individual.

EXAMPLE 1: A K-TAP case consists of mom, dad and two children. Dad is determined incapacitated by the Medical Review Team (MRT) for K-TAP eligibility purposes. Mom is employed or otherwise in compliance with the Kentucky Works Program (KWP) with no evident limitations. An extension is not granted to this family.

EXAMPLE 2: A K-TAP case consists of mom, dad and two children. Dad is determined incapacitated by MRT for K-TAP eligibility purposes. Mom was employed but lost her job as a result of the business closing. An extension, if requested, is reviewed by the Parental Responsibilities Opportunities (PRO) Team because of mom losing her job within 30 days of reaching the 60-month limit, if incapacity for dad still exists.

EXAMPLE 3: A K-TAP case consists of mom, dad and two children. Dad is determined incapacitated by MRT as the deprivation for the case. Mom is determined incapacitated by MRT which is considered good cause for KWP. An extension, if requested, is reviewed by the PRO Team due to incapacity of mom, if incapacity for dad still exists.

B. The reasons for which a K-TAP case can be extended beyond the 60-month limit are as follows:

B – An individual who is battered or subject to extreme cruelty;
M – Has physical or mental condition prohibiting work as determined by the Cabinet;
C – Is required to provide constant care of a family member with a disability and no alternative care arrangement is available;
G – Is a grandparent or other close relative caring for an eligible child who would otherwise be placed in Foster Care;
I – Is an adult with insufficient employment, who has complied with all program requirements including participation in KY Works;
E – A benefit group containing a member who has lost a job within 30 days of reaching the 60-month limit; or

C. When a case is granted an extension, the benefit group must continue to comply with KWP and child support activities. In the case of non-compliance, the case is discontinued manually using procedures found in MS 2002, items C through G. The discontinuance action will pend for supervisory approval.

D. A K-TAP family may be eligible for Work Incentive Reimbursement (WIN) if criteria exist when the case is discontinued at the end of the extension.

Tom Emberton, Jr., Commissioner

Volume III
The following manual section is cross-referenced with this update: MS 2003

MS 99720 PART D MEDICARE DRUG PROGRAM

See Errata To: OM Update No. 06-01, MS 99720, 1/1/06

Many food stamp recipients who also receive Medicare have participated in Medicare's Drug Discount Card Program that began in 2004. Effective January 1, 2006, Medicare will begin phasing out its Drug Discount Card Program and replace it with a new program titled Medicare Prescription Drug Plans or Part D.

"Medicare Prescription Drug Plans", or "Part D" differs significantly from the Medicare Drug Discount Card Program. Details about the program and how it affects Medicare recipients with low income are available at: http://www.cms.hhs.gov/medicarereform/lir.asp.

Implementation of Part D will result in a significant simplification of the food stamp policy relating to the treatment of prescription drug expenses for eligible households. The Food Stamp Program will return to the former policy of considering only unreimbursed out-of-pocket expenses for prescription drugs in determining the household's medical deduction.

For Medicare recipients who have a Medicare Drug Discount Card on December 31, 2005, and who have not enrolled in Part D, the Medicare Drug Discount Card will remain in effect until May 15, 2006, or the effective date of the recipient's enrollment in Part D, whichever comes first.

Therefore, beginning on January 1, 2006, local offices will be working with food stamp applicants/recipients that will fall in the following four categories regarding the Prescription Drug Program:

- Applicants/Recipients that have a valid Medicare Drug Discount Card;
- Applicants/Recipients that are enrolled in Part D;
- Applicants/Recipients that move from the Medicare Discount Card to Part D; or
- Applicants/Recipients that have not enrolled in the Medicare Discount Card Program or Part D.

A. Applicants with a valid Medicare Drug Discount Card who:

1. Apply between January and May of 2006, or recertify between January and April of 2006, will be processed according to current procedures as outlined in Vol. II, MS 5420.

2. Apply after June 1, 2006, or recertify for June 2006, will have their actual out-of-pocket expenses anticipated.

If the recipient does not report the end of participation in the Medicare Drug Discount Program after May 16, 2006, no action is required. The medical expenses will be revised at the next recertification.

B. All Food Stamp applicants or recipients reapplying that are enrolled in Part D should be processed as follows:

1. List the anticipated expenses that will not be reimbursed out-of-pocket expenses (co-pays) and the Part D monthly premium, if applicable.

   NOTE: The state will pay the Medicare Part D premium for recipients of SSI, QMB, SLMB, etc.

2. Budget the recipient's prescription cost following normal rules.

C. All Food Stamp applicants or recipients reapplying that move from the Medicare Discount Card to Part D are processed as follows:

- Determine what the Medicare recipient's out-of-pocket (and possible premium payment) would likely be over the remainder of the certification period and enter necessary changes, and allow the system to process. Reference policy in Vol. II, MS 6707 for change reporting procedures.

D. All Food Stamp applicants or recipients reapplying that have not enrolled in the Medicare Discount Card Program or Part D are processed as follows:

- Anticipate the Medicare recipient's actual out-of-pocket expenses over the certification period as required by normal policy.

The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 contained a specific provision that precluded the Food Stamp Program, and other assistance programs, from reducing benefits because of the Medicare Discount Card. However, the MMA did not contain a similar provision for the new Part D program. Therefore, in most cases, the food stamp allotment will decrease.

Tom, Emberton, Jr., Commissioner

Volume II
The following manual section is cross-referenced with this update: MS 5420.

Errata To:

Volume X
Policy Update

OM Update No. 06-01
1/1/06

MS 99720 PART D MEDICARE DRUG PROGRAM

OM Upd. No. 06-01, Part D Medicare Drug Program, MS 99720, 1/1/06 is revised to clarify that item C should state that all food stamp recipients that move from the Medicare Discount Card to Part D are processed as follows:

Determine what the Medicare recipient's out-of-pocket (and possible premium payment) would likely be over the remainder of the certification period and enter necessary changes. Allow the system to process. Reference policy in Vol. II, MS 6707 for change reporting procedures.

Tom Emberton, Jr., Commissioner

Volume II
The following manual section is cross-referenced with this update: MS 5420
Volume X
The following manual section is cross-referenced with this update: OM Upd. No. 06-01, MS 99720, 1/1/06

MS 99719

SUPPORTS FOR COMMUNITY LIVING AND GROUP LIVING ARRANGEMENTS

As a result of a Food and Nutrition Services (FNS) clarification, policy regarding Group Living Arrangements (GLA) and eligibility for Food Stamp benefits is revised as follows:

It has been determined that not all group homes providing services to Supplemental Security Income (SSI) recipients are certified as GLA's. Some residential group homes are operated under a Medicaid Waiver, know as Supports for Community Living (SCL). SCL provider organizations can be either profit or non-profit.

The residents of these facilities receive supportive services from the organization operating the homes, but the residents are responsible for his/her own shelter and food. Therefore, if all other eligibility requirements are met, these residents may receive food stamp benefits. The local office will need to ascertain what portion of the program fee paid to the SCL provider is for shelter and include that amount in the calculation for food stamp benefits.

In addition, the non-profit requirement for certified GLA's does not apply to organizations participating in the SCL Waiver Program.

Tom, Emberton, Jr., Commissioner

Volume II
The following manual section is cross-referenced with this update: MS 2710

MS 99717 AUTOMATIC DISCONTINUANCE OF K-TAP CASES REACHING THE 60-MONTH LIFETIME LIMIT

See OMTL-329, 4/1/09

Effective November 1, 2005, C and W cases that have members reaching the 60-month lifetime limit without an extension code will be automatically discontinued by the Kentucky Automated Management and Eligibility System (KAMES). The system changes necessary to discontinue cases automatically will move to production October 3, 2005.

The state of Kentucky may incur large financial penalties if individuals receive Temporary Assistance for Needy Families (TANF), K-TAP in Kentucky, benefits beyond the 60-month lifetime limit without a valid verified extension reason and the appropriate extension code entered.

A. KAMES will automatically discontinue a C or W case without an extension code effective with the 61st month with the discontinuance code of 660, "household discontinued due to 60-month K-TAP lifetime limit".

   If appropriate, a case automatically discontinued by KAMES will alternate program to a medical only case but will not alternate program to a Transitional Medical Assistance (TMA) case. A case automatically discontinued by KAMES for code 660 will not pend for supervisor approval or for negative action. A K-TAP case of a probationary worker with a member who has reached the 60-month lifetime limit and has a pending action must be disposed prior to cut-off of the 60th month to end benefits. Payee cases are not affected by this change.

   A case receiving 60 or more months can be manually discontinued. A case manually discontinued will pend for supervisor approval.

B. Ensure all cases facing discontinuance due to the 60-month lifetime limit are manually reviewed at a minimum of three months prior to the potential date of discontinuance. At a minimum, the review should consist of the following items:

   1. Review the IM Tracking Inquiry screens to determine months of receipt to ensure information contained in that file is correct;
   2. Review current situation to determine if the household meets any of the 20% hardship criteria. If applicable, ensure documentation verifying eligibility for the extension is in the case record;
   3. Ensure cases identified for discontinuance are reviewed by the Parental Responsibility Opportunity (PRO) Team prior to discontinuance; and
   4. Determine ongoing eligibility for Medicaid and Food Stamp benefits.

C. KAMES will not automatically discontinue a case with a valid verified extension reason and the appropriate extension code entered.

   To identify a case that is determined eligible for extending the receipt beyond

the 60-month limit, enter the code for the appropriate extension reason on KAMES Application Members or Change – Case General Screens. The appropriate extension codes are:

B - An individual who is battered or subject to extreme cruelty;

M - Has a physical or mental condition prohibiting work as determined by the Cabinet;

C - Is required to provide constant care of a HH member, who is a parent, spouse, or child with a disability and no alternative care arrangement is available;

G - Is a grandparent or other close relative caring for an eligible child who would otherwise be placed in Foster Care;

I - Is an adult with insufficient employment, who has complied with all program requirements including participation in Kentucky Works; or

E - A benefit group containing a member who has lost a job within 30 days of reaching the 60-month time limit. This extension can only be given for 3 consecutive months. Once received, it can not be used again.

"N – No, not eligible for the 60-month extension" is no longer a valid extension code. If an N is entered to the question, "5 Year Lifetime Limit Extension Reason", the error message, "Above Highlighted Field in Error" is received.

When an extension code is entered or changed, the case will pend for supervisor or principle approval. When the extension code is removed, if the individual has received 60 months or more of K-TAP benefits, KAMES will automatically discontinue the case the next administratively feasible month.

The extension code field is no longer a mandatory field. The field is blank unless an appropriate extension code is entered.

D. The question on screen HRKIPA03, Application – Application Members, regarding the K-TAP lifetime limit is revised to read "5 Year Lifetime Limit Extension Reason: _" and "Extend How Many Months? _". Allowable entries for the question "5 Year Lifetime Limit Extension Reason:" are B, M, C, G, I and E or blank. The valid entries to "Extend How Many Months?" are the number of months the case is extended beyond the 60-month limit for the extension code entered.

Example: The appropriate extension code entered for the individual is C. If code C is entered, 6 is entered for "Extend How Many Months?". Six is the number of months the case is extended beyond the 60-month limit before a review of the case is due.

The revised question will also display on screens HRKIMD01, Change - Case General Information; HRKIPK03, Inquiry – Application Members; and HRKIMK26, Inq – Case General Information.

E. Cases currently extended under the 20% hardship criteria must be manually reviewed a minimum of two months prior to the potential date of discontinuance unless the case is extended using extension code M. This is done to ensure that no case is discontinued incorrectly or is discontinued timely, if appropriate. The potential date of discontinuance is the date the extension is due to expire.

1. Review to determine if the household continues to meet any of the 20% hardship criteria.

    a. A case extended under the 20% hardship criteria using extension code M and requiring a redetermination from MRT is reviewed a minimum of three months prior to the potential date of discontinuance.
    b. Ensure form PA-601T, Referral for Medical Determination, is sent to MRT for a redetermination a minimum of three months prior to the potential date of discontinuance.
    c. When form PA-601T is sent to MRT, annotate in red on the top of the form that the case is a 60-month redetermination.
    d. To receive extended K-TAP benefits, the individual must comply with the treatment or other activities recommended by the referral source approving the extension, such as MRT, Targeted Assessment Project (TAP), CompCare or Vocational Rehabilitation (VR). If the individual fails to comply with the treatment or activities, the extension code is removed and the case is manually discontinued or allowed to automatically discontinue.

2. Ensure verification of the extension is in the case record.

3. If not eligible for continuing the extension, remove the extension code and number of months. Determine eligibility for Medicaid and Food Stamp benefits. KAMES will automatically discontinue the case the next administratively feasible month.

F. If a reapplication or reinstatement action is taken, a system prompt, “Member has received 60 or more months”, is in place. If the prompt is received, ensure that the individual has received his/her 60-month limit correctly. If the individual has met the 60-month limit, determine if he/she meets one of the criteria for an extension.

A reapplication or reinstatement action taken for a household that consists of a member that has received 60 months or more will pend for supervisory approval. The supervisor reviews the case to ensure all appropriate action has been taken and the case was discontinued correctly for the 60-month limit. Once the supervisor ensures the case was discontinued correctly for the 60-month limit and the individual is not eligible for an extension, the case action will deny.

KAMES will deny the application for a household who makes application for K-TAP after receiving 59 countable months and is not eligible for an extension, and on-going benefits. If the household is K-TAP eligible for the 60th month of benefits and not on-going, the 60th month benefit is paid by special circumstance.

G. The K-TAP individual may be eligible for the Work Incentive Reimbursement (WIN) if the criterion is met when the case is automatically discontinued.

H. Any case discontinued for the 60-month limit will be offered Safety Net services through a home visit from a Protection and Permanency (P & P) staff member. Send form PAFS-628, Exchange of Information, to inform the local P & P section to initiate Safety Net procedures.

I. Households discontinued for the 60-month limit are NOT eligible for FAD.

J. The report, HR-KIMR-60, K-TAP 36-Month Report, is modified to incorporate report HR-KIMR-8D-01, Cases with 60-Month K-TAP Extension. The following columns of the HR-KIMR-60 have been modified or added:

1. "Countable Months Recd" - displays the actual countable months an individual has received K-TAP benefits;

2. "Ext Code" – displays the extension code if one is entered. If an extension code is not entered, the column will be blank; and

3. "Countable Months Recd Over 60" – displays actual countable months an individual has received over the 60-month limit. If the case has not received over the 60-month limit, the column will be blank.

K. Effective November 1, 2005, a review of cases facing discontinuance due to the 60-month lifetime limit using the modified 36-month report, HR-KIMR-60, is required locally on a monthly basis to ensure accuracy and that those cases nearing the 60-month lifetime limit are receiving benefits appropriately. See Item B.

The HR-KIMR-60 report is run the 2nd workday of each month. When the report is produced, Central Office will send a monthly e-mail advising the report is available to supervisors with copies to the SRAs, SRAAs, Regional Office Program Specialists and KWP Coordinators.

Ensure each case on the report with an extension receiving beyond the 60 months has the appropriate extension code and correct documentation is filed in the case record.

1. Annotate each individual name listed on the report indicating if the extension code is correct or if the case has been corrected and will be removed from the report.

2. Provide monthly reports to a designated individual in your region.

3. The individual designated at the Regional level mails the last HR-KIMR-60 report received for the quarter annotated with the results of the review for that month to the Family Self-Sufficiency Branch (FSSB).

4. FSSB will begin quarterly reviews of the annotated HR-KIMR-60 report. The annotated reports for December, March, June and September are to be forwarded to FSSB.

5. The first quarterly report is due c.o.b. January 16, 2006. Send the results of the reviews to:

   Cabinet for Health and Family Services
   Department for Community Based Services
   Division of Family Support
   Family Self-Sufficiency Branch
   275 East Main Street, 3E-I
   Frankfort, Kentucky 40621-0001

6. Effective November 1, 2005, it is no longer required for staff to send the annotated HR-KIMR-8D-01 to FSSB.

L. To alert the worker of a case reaching the 60-month lifetime limit, the spot check "59th K-TAP Month Review Case" will post to the worker's Daily Case Status Report (DCSR). This spot check has a timely date of seven days. If the worker does not act on the spot check within seven days, the spot check will post as nearing the time limit to the supervisor's DCSR. The spot check will automatically delete when the case is discontinued or an extension code is entered. The supervisor or worker can manually delete the spot check, if appropriate.

M. A pending recertification for a K-TAP case with a member who has reached the 60-month lifetime limit will not automatically discontinue. This may cause an individual to receive over the 60-month lifetime limit. To monitor these cases, a new report, HRKIPR74, Countable Pending Recerts Report, will run the first weekend of each month beginning November 2005 and will contain a listing of cases pending recertifications.

1. Any case that has issued 60 countable months of K-TAP benefits and is in pending status at the time the last automatic discontinuance of 60-month cases occurs will be listed on the report.

   Example: A recertification is begun and pended on October 10, 2005, and remains pending at first issuance. The first issuance is the 60th countable month for the case with the 60th countable month being November 2005. The case will be on the report that runs on the first weekend in November 2005.

2. A designated individual from each Region is to monitor the report to ensure the pending case action is processed prior to cut-off. FSSB will also monitor the report, and if appropriate action is not taken, will notify the SRAs, SRAAs and Program Specialists. The report will display on RDS and DocumentDirect 2.2 or 2.3.

3. The HRKIPR74 report will have a countable months column, countable months over 60 column, and a column for an extension code if one was

entered before the pending action. The report will have page breaks by regions and county and sorted by unit, caseload, and case number.

N. When a client requests a hearing timely for a case discontinued due to the 60-month lifetime limit, the benefits remain inactive pending a hearing decision unless the client specifically requests the benefits continue, including supportive services. If the client requests continuation of benefits timely, reinstate benefits within 5 work days to the level prior to the timely notice, if it was discontinued or reduced as a result of the timely notice. Explain to the client that if the Agency's decision is upheld, any overpayments resulting from continuation of benefits must be repaid.

If a hearing request is received for a case that has received over the 60-month lifetime limit and the client requests benefits continue, enter the most appropriate extension code to allow benefits to remain active until a hearing decision is received.

Tom Emberton, Jr., Commissioner

Volume III
The following manual sections are cross-referenced with this update: ~~MS 2002~~ and MS 2003

MS 99712 CO-PAY FOR MEDICAID RECIPIENTS

See OMTL-281, 8/1/07
See Errata to: OM Update No. 05-28, MS 99712, 9/1/05

Beginning July and August, 2005, the Department for Medicaid Services (DMS) will increase some existing co-payments and several new co-payments will be implemented due to an amendment to 907 KAR 1:604.

A. Effective July 15, 2005, certain Medicaid recipients will be subject to the following increased co-payments on prescription drugs:

1. $1 co-pay for generic drugs or atypical antipsychotic drugs without a generic equivalent;
2. $2 co-pay for drugs without a generic equivalent and that are available under the supplemental rebate program; and
3. $3 co-pay for non-preferred brand name drugs.

B. The recipient is responsible for paying the co-payment to the pharmacy at the time the prescription is filled. If the recipient is unable to pay the co-payment at the time the prescription is picked up, the pharmacy cannot deny his/her prescriptions. However, the individual is still responsible for paying the co-payment. The recipient has the obligation to pay what is owed to the pharmacy. Pharmacies that have trouble collecting these co-payments may decide to stop providing serves to Medicaid patients.

C. A new co-payment of $3 for each emergency room visit that Medicaid deems a non-emergency, such as for allergies or sore throat, is effective August 1, 2005.

D. A co-payment of $2 by the recipient will now also be required for services rendered by the following providers:

1. General ophthalmologic services provided by physicians;
2. Advanced Registered Nurse Practitioners (ARNP);
3. Rural health clinics;
4. Primary care centers; and
5. Physician's office (effective 8/1/05).

The $2 co-payment is payable by the Medicaid recipient to the provider at the time of service.

E. Effective August 1, 2005, recipients will be required to pay $50 per recipient, per provider, per date of service for each covered admission to a hospital for inpatient hospital services.

F. The $2 co-payment effective May 1, 2003, for some Medicaid, QMB and KCHIP recipients for certain services rendered by the following providers has not changed:

1. Dentists;
2. Optometrists;
3. Opticians;
4. Audiologists;
5. Hearing Aid Dealers;
6. Chiropractors; and
7. Podiatrists.

G. The following recipients are exempt from the co-pay requirement:

1. Children under age 18:

   a. If the 18th birthday is on the first day of the month, the individual is subject to the co-payment.
   b. If the 18th birthday is after the first day of the month, the individual is exempt from the co-payment until the following month.

2. Recipients in long-term care facilities (Nursing Facilities and ICF/MR/DD's);

3. Recipients who reside in Personal Care Homes (PCH) and Family Care Homes (FCH);

4. Recipients receiving Hospice services (institutionalized and non-institutionalized);

5. Waiver recipients (ABI, Adult Day, HCBS, Model Waiver II and SCL);

6. Pregnant women, through the 60-day postpartum period;

7. Presumptively eligible pregnant women, during the presumptive eligibility period;

8. Recipients age 18, who are in state custody and are in foster care or residential placement;

9. Recipients covered by the Passport Health Plan, except for prescriptions not covered by Passport, such as those written by psychiatrists; and

10. KCHIP recipients, age 18-19, who are of Alaskan/Native American ethnicity.

H. Recipients cannot be denied care by a provider because of the inability to make required co-payments at the time of service. However, the co-payment remains the responsibility of the recipient. With prior notice, providers may, as a business practice, choose to discontinue future services for recipients with a history of non-payment.

I. Notices will be mailed to Medicaid, KCHIP and QMB recipients prior to implementation of this new co-payment procedure. Field staff is to explain the co-payment requirement to individuals during application and recertification interviews.

J. Recipients that are eligible for a medical deduction may use verified co-

payments in their Food Stamp and Medicaid cases.

Tom Emberton, Jr., Commissioner

~~Volume I~~
~~The following manual section is cross-referenced with this update:~~ ~~MS 0097~~
Volume II
The following manual sections are cross-referenced with this update: MS 5420 and MS 5430
~~Volume IV~~
~~The following manual section is cross-referenced with this update:~~ ~~MS 3990~~
~~Volume IVA~~
~~The following manual sections are cross-referenced with this update:~~ ~~MS 1055~~, ~~MS 2700~~ ~~and~~ ~~MS 3480~~
~~Volume VI~~
~~The following manual section is cross-referenced with this update:~~ ~~MS 3530~~

MS 99712 CO-PAY FOR MEDICAID RECIPIENTS

See OMTL-281, 8/1/07

This Errata is issued to clarify policy concerning co-pays for Medicaid recipients. This clarification is the result of additional information received by the Department for Medicaid Services.

OM Update No. 05-28, MS 99712, 9/1/05, Item G.5, states waiver recipients (ABI, Adult Day, HCBS, Model Waiver II and SCL) are exempt from the co-pay requirement. That statement is partially true. They are exempt from service co-pays; they are NOT exempt from prescription drug co-pays.

Tom Emberton, Jr., Commissioner

~~Volume I~~
~~The following manual section is cross-referenced with: "Errata to: OM Update No. 05-28, MS 99712, 9/1/05".~~ ~~MS 0097~~
Volume II
The following manual sections are cross-referenced with: "Errata to: OM Update No. 05-28, MS 99712, 9/1/05". MS 5420 and MS 5430
~~Volume IVA~~
~~The following manual sections are cross-referenced with: "Errata to: OM Update No. 05-28, MS 99712, 9/1/05".~~ ~~MS 1055, MS 2700 and 3480~~
~~Volume VI~~
~~The following manual section is cross-referenced with: "Errata to: OM Update No. 05-28, MS 99712, 9/1/05".~~ ~~MS 3530~~
Volume X
On OM Update No. 05-28, MS 99712, 9/1/05, the cross-reference to Volume IV, MS 3990, is deleted as this section was previously obsoleted. OM Update No. 05-28, MS 99712, 9/1/05, is cross-referenced with: "Errata to: OM Update No. 05-28, MS 99712, 9/1/05".

MS 99706 K-TAP 60-MONTH LIFETIME LIMIT DISCONTINUANCE

See OMTL-329, 4/1/09

It is imperative that all C and W cases reaching the 60-month lifetime limit without an appropriate extension code are discontinued using code 660, "household discontinued due to 60-month K-TAP lifetime limit" effective with the 61st month. The state of Kentucky may receive large financial penalties if individuals receive K-TAP benefits beyond the 60-month lifetime limit without a valid verified extension reason and the appropriate extension code entered.

A. Cases facing discontinuance due to the 60-month lifetime limit must be manually reviewed at a minimum of three months prior to their potential date of discontinuance.

   At a minimum, the review should consist of the following items:

   1. Review the IM Tracking Inquiry screens to determine months of receipt to ensure information contained in that file is correct;
   2. Review to determine if the household meets any of the 20% hardship criteria. If applicable, ensure documentation verifying eligibility for the extension is in the case record;
   3. Cases identified for discontinuance are reviewed by the PRO team prior to discontinuance; and
   4. Determine eligibility for ongoing Medicaid and Food Stamp benefits.

B. If a case has reached the 60-month lifetime limit prior to the manual review and PRO team review, discontinue the case before completing the reviews.

   Example 1: A recipient has received 40 months of K-TAP benefits. The recipient reported he/she never received TANF in another state. It is discovered at a later date the recipient received 25 countable months of TANF in another state. The recipient has now received 65 countable months of TANF. Discontinue the K-TAP case immediately unless verified eligibility for an extension exists. Do not keep the case active pending a determination of an extension reason. If the individual is determined eligible for an extension, the case is reinstated as appropriate and verification is filed in the case record.

   Example 2: A worker reviews IM Tracking Inquiry screens. The recipient has received 50 months countable toward the 60-month lifetime limit coded as "Y" and 16 months coded as "YE", "No specific condition exists, exempt." The worker discovers the 16 months coded as "YE" are coded incorrectly and changes the code to "Y". The recipient now has 66 months countable toward the 60-month lifetime limit. Discontinue the K-TAP case immediately unless verified eligibility for an extension exists. Do not keep the case active pending a determination of an extension reason. If the individual is later determined eligible for an extension, the case is reinstated as appropriate and verification is filed in the case record.

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K-TAP cases discontinued for the 60-month lifetime limit prior to a manual and PRO team review must have a manual and PRO team review completed within 30 days from the date of discontinuance of the K-TAP case.

C. A K-TAP adult who has a physical or mental condition (e.g., emotional, learning, behavioral) prohibiting work as determined by the Cabinet may receive an extension of the 60-month lifetime limit.

When an extension of the 60-month lifetime limit is requested due to a physical or mental condition and it is appropriate to request a determination from the Medical Review Team (MRT), ensure form PA-601T, Referral for Medical Determination, is sent to MRT for a determination a minimum of three months prior to the individual reaching their 60-month lifetime limit.

When form PA-601T is sent to MRT, annotate in red on the top of form PA-601T that the case is 60-months. When contacting MRT regarding a determination for a case, provide the patient's name and social security number and indicate the date that the request was sent to MRT. MRT logs in forms PA-601T by the date of receipt.

If MRT does not provide a determination by the 60th month, discontinue the K-TAP case. A reinstatement of the case may be made if a determination by MRT is one of the following:

1. Incapacity exists and no further action is required;
2. Incapacity exists and certain activities should be carried out to enhance the client's personal, social, or job functioning; or
3. Incapacity exists for a time-limited period to permit diagnostic and other activities to enhance or definitely determine employability.

If appropriate, reinstate the case within 10 days from the date determination is received from MRT. Ensure the correct extension code is entered and verification is filed in the case record.

D. Cases currently extended under the 20% hardship criteria must be manually reviewed a minimum of two months prior to the potential date of discontinuance. This is done to ensure that no case is discontinued incorrectly and the case can be discontinued timely, if appropriate. The potential date of discontinuance is the date the case is due for review of the 20% hardship criteria.

1. Review to determine if the household continues to meet any of the 20% hardship criteria;
2. Ensure verification of the extension is in the case record; and
3. If not eligible for continuing extension, determine eligibility for Medicaid and Food Stamp benefits.

E. When a client requests a hearing within 10 days of the date on the timely notice, the benefits remain inactive or reduced pending a hearing decision unless the client specifically requests that the benefits continue, including supportive services.

If the client requests continuation of benefits within 10 days of the date on the timely notice, reinstate benefits within 5 work days to the level prior to the timely notice if it was discontinued or reduced as a result of the timely notice. Explain to the client that if the Agency's decision is upheld, any overpayments resulting from continuation of benefits must be repaid.

If the request is received within 20 days of the date of the timely notice, and the client claims good cause for not reporting within 10 days, determine if the reason for the delay meets the following good cause criteria:

1. The client was away from the home during the entire timely notice period;
2. The client was unable to read or comprehend the timely notice and the right to request a fair hearing;
3. The client moved, which resulted in a delay in receiving or failure to receive the timely notice;
4. The client had a serious illness; or
5. The delay was no fault of the client.

If the reason meets good cause criteria and the client requests that the benefits continue, reinstate the case within 5 work days to the level prior to the timely notice if it was discontinued as a result of the timely notice.

Accept the client's statement for good cause unless there is a reason to doubt.

Mike Robinson, Commissioner

Volume I
The following manual sections are cross-referenced with this update: ~~MS 0577~~
Volume III
The following manual sections are cross-referenced with this update: ~~MS 2002~~ and MS 2003

MS 99697 CHANGES IN PROCESSING OF APPLICATIONS, RECERTIFICATIONS, PROGRAM TRANSFERS, MEMBER ADDS AND CONVERSION RECERTIFICATIONS THAT PEND FOR SUPERVISORY APPROVAL

See OMTL-329, 4/1/09

Effective February 7, 2005, the capability for over-the-shoulder sign off by a supervisor or principal was eliminated on applications, recertifications, program transfers, member adds and conversion recertifications that pend for mandatory supervisory approval. This change affects the following program codes: C, E, F, G, H, FP, GP, HP, I, J, K, KC, L, M, N, P, T, U, W, Y and Z. That was the only change to the process. The pending actions will display on the worker's and supervisor's DCSR as in the past. Actions that do not pend for supervisory approval are not changed by this process.

Effective with this change, when a probationary worker or any worker hits "enter" to process one of the actions described above, the supervisor sign off field will no longer be seen. The prompt "ACTION PENDED - GIVE FILE TO SUPV/PRIN" will be seen. To successfully sign off on a case, the supervisor, principal, or designated individual must be logged on to KAMES in his/her own "HRII" code. The terms, supervisor and principal, in this context, apply to individuals coded with KAMES security clearance type 02 (supervisors) and type 24 (principals). In order for a designated individual to sign off, the designated individual must have a security clearance of type 02 or type 24. These are the individuals with clearance to sign off on an action. It does not refer to an individual's personnel classification.

Additionally, a new report, HRKIPR65, RPT OVER THE SHOULDER SUP APPROVAL REPORT, is created at the end of each month and stored on RDS to capture all of the actions described above that were initiated and approved by supervisors and principals for the previous month. This report will have the region, county, unit, caseload code, program code, case name, case number, mailing address, action type, action date and approver ID. The reports will be sorted by region name, county, unit, caseload code and action type.

Regional office staff are to review this report for irregularities on a monthly basis in the same manner HRKRPR6B, RPT REPLACEMENT, SUPPLEMENT, RESORATION REPORT, and HRKRPR6C, RPT REPLACEMENT, SUPPLEMENT, RESORATION REPORT BY SUPERVISOR, are reviewed.

Mike Robinson, Commissioner

Volume I
The following manual section is cross-referenced with this update: MS 0458
Volume III

The following manual section is cross-referenced with this update: ~~MS 2010~~
~~Volume IV~~
~~The following manual section is cross-referenced with this update:~~ ~~MS 2810~~
~~Volume IVA~~
~~The following manual sections are cross-referenced with this update:~~ ~~MS 2740~~, ~~MS 4500~~, and ~~MS 4595~~
Volume VI
The following manual sections are cross-referenced with this update: MS 5450 and MS 5460

MS 99696 VERIFICATION OF ZERO INCOME

See OMTL-294, 6/1/08

In an effort to make policy consistent between programs, it is now necessary to verify lack of income for K-TAP and Family MA as well as food stamps. This affects cases in K-TAP and Family MA categories of: C, E, I, L, N, T, W and Y cases.

Effective March 1, 2005, use the following policy and procedures to process cases with zero income.

A. For K-TAP C and W cases, verify zero income for all IM members age 18 years or older with an "M" status and limit verification to "R" members with the following status: R-40, R-41, R-42, R-43, R-48, R-49, R-50, R-57, R-58 and R-59.

B. For MA; E, I, L, N, T and Y cases, verify zero income for the head of household who is age 18 years or older. For E and T cases, it is at the worker's discretion to verify zero income for the other adult member.

C. KAMES processing has been changed to allow these cases to pend for verification of no income. A Request for Information (RFI) letter is system generated requesting verification of zero income based on the response to a new question on KAMES. RFI text on notices and the RFI screen will be "No Income". The new question, “Is proof of no income required?”, displays on KAMES for the head of household or a case member aged 18 or older. The screen has been rearranged to accommodate the question. This new question displays for applications, recertifications, and inquiry. The new question will not display at case change for “M” members but will display for “R” members listed in item A. The screen will be revised to display the question “Is proof of no income required?” at case change for “M” members in the near future.

D. At member level, the question is protected for all members under age 18 unless he/she is the head of household. At application and member-add, an individual is considered 18 if he/she becomes 18 during the application month. At recertification, a member is considered 18 if he/she is 18 within the first month of the new certification period. An 18-year old child (M05 or M07) in the case, attending school full-time, is not required to verify zero income. Therefore, the worker enters “N” to the question.

E. For a recertification involving form KIP-2SR, Recertification Notice for KCHIP and Medicaid, or KIP-2SRA, Renewal Form for Medical Coverage Final Notice, when the only information missing on the form is verification of zero income, it is necessary to enter the recertification on KAMES and make it pend. Send the client an RFI or PAFS-2 requesting verification of zero income for the head of household to be returned within 10 days.

Kinship Care, P and U cases are excluded from this change as are all Adult MA programs (codes F, G, H, FP, GP, HP, J, K, M and Z).

With this OM Update the instructions in Volume VI, MS 3120, Pending for Zero Income, are now to be disregarded. Revisions to Volume VI will be made in a future transmittal.

Mike Robinson, Commissioner

Volume III
The following manual section is cross-referenced with this update: MS 2500.
~~Volume IV~~
~~The following manual sections are cross-referenced with this update:~~ ~~MS 3500, MS 3700 and MS 4360.~~
Volume VI
The following manual section is cross-referenced with this update: MS 3120.

MS 99694 TRACKING K-TAP MONTHS OF RECEIPT FOR FELONS

Currently, a case with a convicted drug felon who is technically excluded is not considered toward the 60-month count and months of receipt of K-TAP benefits are tracked as excluded (FE) on KAMES.

However, while months of receipt by technically excluded fleeing felons and probation/parole violators did not count toward the 60-month count, they were tracked on KAMES and considered as months of receipt.

Current policy states that the 60-month lifetime limit for receipt of K-TAP benefits does not apply to cases containing these individuals. It is anticipated that policy changing the months of K-TAP receipt in C and W cases by drug felons, fleeing felons and probation/parole violators, as countable toward the 60-month lifetime limit will be in effect June or July of 2005. Notification of that change will be issued prior to the effective date.

A. To assist with the implementation of the anticipated change in policy:

1. KAMES will begin to track months of receipt of K-TAP benefits by drug felons, fleeing felons and probation/parole violators with “F”, felon, as the tracking code effective February 7, 2005. Member codes tracked are M03, M04, M06, M13 and M14. The “E” code, exempt, as the second digit is an allowable entry.

2. Until the effective date of the change in policy, KAMES will monitor these cases on a monthly basis and change the “F” code to “FE”, felon exempt, to exempt these months from the 60-month count.

B. There are currently under 200 drug-felons and approximately 10 fleeing felon and probation/parole violators statewide. Individuals convicted of a drug felony after August 22, 1996 are only allowed good cause for the following reasons:

1. Is assessed as chemically dependent and is participating in or has successfully completed a recognized chemical dependency treatment program. The individual must have committed and been convicted of a drug felony after August 22, 1996 and must have entered into or completed a chemical dependency program after August 22, 1996. The individual may meet this requirement by participating in or completing any recognized chemical dependency program.

2. Is pregnant. The individual is eligible for benefits during the pregnancy only; and

3. Is otherwise eligible for benefits.

Individuals convicted of a drug felony who have not been assessed as chemically dependent are technically excluded regardless of the fact they have completed a drug treatment program.

C. The question, "IS HE/SHE A FLEEING FELON OR PROBATION/PAROLE VIOLATOR?" is required for members in a C or W case at application, program transfer, or member add. Valid entries are "Y" or "N".

1. Effective February 7, 2005, this question is tied to the disqualification process. If answered "Y", KAMES automatically changes the IM ID code of the member to M13, M15 or M16 as appropriate, a 441 disqualification is imposed, member status code 841 is posted, and "F" is posted to IM Tracking screens. There is no change to the way the disqualification is imposed or to the notices sent when the disqualification is imposed.

2. When the disqualification is imposed, the member is ineligible for K-TAP benefits but is eligible for a MAID card. The member's income, resources, etc., will continue to be counted in the case.

3. The system prompt "ENTER DISQUAL AS APPROPRIATE FOR FELON/PROB/PAROLE VIOLATOR" is removed.

Prior to discontinuance of a case for the 60-month lifetime limit, follow existing policy and review the hard copy case record to monitor the months received to ensure correctness.

Mike Robinson, Commissioner

Volume III
The following manual sections are cross-referenced with this update: MS 2002 MS 2215

MS 99693

NONCUSTODIAL PARENT (NCP) KAMES REFERRAL

Effective February 7, 2005, revisions are made to the KAMES KASES child support referral screens on which workers enter information on KAMES which pertains to a non custodial parent (NCP) or parents. Revisions include new screens and new questions. The current data entry screens for the client and children are not changed. The designation of NCP will replace the current designation of absent parent (AP) on all referral screens. Changes in the designation "NCP" on all forms currently indicating "AP" will occur as each form is revised.

A. Workers complete the child support referral process at each application and member-add. Information is updated at recertification and during program transfers or interim changes. Information entered on KAMES KASES screens updates KASES with information concerning the client, children included in the case, and the NCPs.

B. Information provided by the client regarding the NCP is entered on the referral screens using the following procedures:

1. Once the NCP is identified, a set of trigger questions is displayed and answered according to information given by the client. Depending on how trigger questions are answered, specific KAMES screens, which relate to the information asked for in the trigger question, will appear. If no information is available from the client concerning the question asked, the corresponding screen will not appear.

   Example: Do you know where the NCP lives? A valid response would be either "Y" or "N". If "Y" is indicated, after all 13 trigger questions are answered, one of the screens that appears will allow information about the NCP's address to be entered. The worker enters only information that is provided by the client on the KAMES screen.

2. Workers can access the trigger question screen from another screen by entering "trigge" in the next action field.

3. During the previous referral process on KAMES, it was mandatory that required fields have an entry before the worker was allowed to move off the screen. This change will make is possible to leave a screen even though some fields on the screen are left blank. Workers should make every effort to enter all required information on each screen, but if the client is unable to provide information, the worker is able to move forward in the referral process. At no time should a worker enter fictitious information in an effort to leave a screen. This information is utilized by the Division of Child Support (DCS) in making determinations concerning paternity and support and it is of extreme importance that it be up-to-date and accurate.

   If, during the course of the interview, the client appears to be providing information related to the NCP that is blatantly false, enter the information

given by the client and document in comments that all entries were entered as stated by the client and appear to be false.

4. If “Y” is answered to a trigger question, some form of information is required on the corresponding information screen. If information is not entered, the worker will not be able to exit the screen when he/she first hits “Enter”. Instead, the system prompt “No info entered, conflicts with trigger question” is displayed. At this point, the worker can:

   a. Hit “Enter” again and be taken back to the corresponding trigger question where he/she can change the trigger answer to “N”, if appropriate; or
   b. Enter information.

   Example: Can you describe the NCP? Again, either “Y” or “N” is correct.

   If the client indicates partial information is known, (e.g., color of hair, weight) answer "Y". Once this information is entered on the corresponding information screen, the worker can move to the next screen.

5. A new inquiry screen will be available to indicate how answers are entered on trigger questions. Information previously entered on referral screens will remain uploaded so a worker can review and make necessary changes. The information will remain uploaded for recertifications, all interim changes, and reapplications.

   Example: A month after the referral is made, the client indicates she did not give an address for the NCP. The worker inquires the trigger question screen and notes that “N” is answered to the question, “Do you know where the NCP lives?” During the interim change on KAMES, the worker can answer “Y” to that question on the trigger screen and enter the NCP address on the corresponding information screen.

6. Wording has been changed on certain current screens to better indicate the purpose of the information being requested. For example, instead of “alias”, the text will now indicate “other name 1” and “other name 2”. A person with the name “John Smith” may go by "Jay" or "Smitty" and this needs to be noted on this screen.

7. The worker can enter from any screen during the referral process by entering the next action command “knotes”. This gives the worker the opportunity to add information not specifically asked for on a trigger screen, to explain the lack of information, or to make other explanations on behalf of the client. Workers’ observations and other pertinent information shown in comments can assist DCS when provided via the KAMES child support referral. The “knotes” command can be used from any screen during the NCP, client or child navigation. Once comments are updated, the worker will be returned to the last screen viewed prior to the “knotes” command.

C. Previously, referral information screens contained edits requiring entry of certain information before the worker was allowed to move off the screen. To facilitate the change and improve the process, those edits are removed from

information screens for the client and children. Workers must make every effort to enter all required information on each screen, but if the client is unable to provide the information, the system can still move forward in the referral process. It is recommended that staff document references to "unknown" or excessive lack of detailed information in comments.

D. Form KIM-125 will be revised to change references from absent parent to NCP.

Mike Robinson, Commissioner

Volume III
The following manual section is cross-referenced with this update: MS 3030.
Volume VI
The following manual section is cross-referenced with this update: MS 5005.

MS 99690 LONG TERM CARE CERTIFICATION AUTOMATION

See OMTL-294, 6/1/08

Effective with the February 7, 2005, KAMES release, Long Term Care (LTC) certifications from the Peer Review Organization (PRO) are issued electronically. This process replaces the paper Confirmation Notice, L02, MAP-4200 and Prior Authorization Letter. LTC certifications issued by the PRO prior to the effective date will generate paper forms. Supports for Community Living (SCL) and Acquired Brain Injury (ABI) certifications are excluded from this automated process until further notice.

The automated process includes an SSN matching function which searches KAMES for an active or pending member. If a match is found, the system will post a spot check to the worker's DCSR with the message, "Pending PRO Certifications". The spot check will appear on both the worker's and supervisor's DCSR's if the worker is on probationary status. The spot check will appear on the supervisor's DCSR for a non-probationary worker if no action is taken after 10 days. Additionally, a new menu item titled, "Pending PRO Certifications" is added to the DCSR Menu as #10 under Pending Case Actions (C).

Workers are to access the certification files for identified matches from the new item "P", PRO Certifications, on the KAMES Inquiry Menu. The certification is to be force printed and filed in the case record.

If no SSN match is found on KAMES, the member name, SSN and facility number will appear on the new RDS report titled, "PRO Certifications Not Matched to KAMES". The member information is sorted by county code. Supervisors are responsible for monitoring this report on a daily basis and assuring that PA-62's are completed for vendor payment approval for individuals active on SDX. This will be the location of the certifications for SSI individuals and individuals that are not active Medicaid recipients on KAMES at the times the file is received. Workers are to access the certification files for identified clients on item "P" of the KAMES Inquiry Menu. The certification is to be force printed and filed in the case record.

When a worker adds a new LTC segment to KAMES, matching the provider number and member number of a pending PRO Certification, the spot check will disappear when the batch cycle is run. Only the supervisor will have the capability to manually delete the PRO Spot Check. In order for the supervisor to manually delete the PRO Spot Check, a new field is added to the Daily Case Status Maintenance Menu. Select function K, Delete PRO Spot Check, and hit enter. The supervisor will enter an X next to the spot check to be deleted and hit enter. The X(s) will be highlighted with a message that states "press enter to confirm deletion". When enter is pressed again the supervisor will receive a message stating "record deletion successful". The listing will remain unchanged until batch is run.

A new verification source of "PR" is added on the LTC screen of KAMES for the following types of care: 01 (Nursing Facility), 02 (HCBS), 07 (ICF/MR/DD), 08 (Mental Health/Psychiatric), 09 (PRTF), 10 (Adult Day Care) and 12 (IMD).

For cases on the PA-62 system, the Computer Manual, Section II, Public Assistance Program, is updated to add a new verification source for field 92. The new code is “6-PRO Certification”, and will be appropriate for the following levels of care: Nursing Facility, HCBS, ICF/MR/DD, Mental Health/Psychiatric, PRTF, Adult Day Care and IMD. The error code 321 is also updated to state "Notification form number must be 1, 2, 3, 4, 5 or 6".

Mike Robinson, Commissioner

~~Volume IV~~
~~The following manual sections are cross-referenced with this update:~~ ~~MS 2690~~ and ~~MS 2710.~~
~~Volume IVA~~
~~The following manual sections are cross-referenced with the update:~~ ~~MS 2110, MS 2820, MS 2890, MS 2910, MS 2990, MS 3350,~~ ~~MS 3360, MS 3370, MS 3380, MS 3410, MS 3650~~ and ~~MS 3660.~~
Volume VI
The following manual section is cross-referenced with this update: MS 3810.

MS 99688 CHANGES IN PROCESSING OF RESTORATIONS, REPLACEMENTS AND SUPPLEMENTALS

See OMTL-329, 4/1/09
See OM Upd. No. 07-21, MS 99770, 10/1/07
See OM Upd. No. 08-02, MS 99778, 2/4/08

Effective January 4, 2005, the capability for over-the-shoulder sign off by a supervisor or principal is eliminated on manually issued restorations, replacements and supplementals. This is the only change to the process. The pending actions will display on the worker's and supervisor's DCSR as in the past. Supervisors continue to have the capability to initiate and sign off on restorations, replacements and supplementals.

Effective with this change, when a probationary worker or any worker hits "enter" for a manually issued Food Stamp replacement or restoration or a K-TAP or Food Stamp supplemental, the supervisor sign off field will no longer be seen. The prompt "ACTION PENDED - GIVE FILE TO SUPV/PRIN" will be seen. To successfully sign off on a case, the supervisor, principal, or designated individual must be logged on to KAMES in his/her own "HRII" code. The terms, supervisor and principal, in this context, apply to individuals coded with KAMES security clearance type 02 (supervisors) and type 24 (principals). In order for a designated individual to sign off, the designated individual must have a security clearance of type 02 or type 24. These are the individuals with clearance to sign off on an action. It does not refer to an individual's personnel classification.

Additionally, two new reports are created and stored on RDS to capture manually issued replacements, supplementals and restorations. Each report will have the region, county, unit, caseload code, program code, case name, case number, mailing address (except for food stamp transactions), issue type, issue date and amount. The reports will be sorted by region name, county, unit and caseload code and will display a total for each worker and county. The first report will capture actions initiated by workers and principals and the second report will capture actions initiated by supervisors. MA replacements will not be captured on the reports. Reports are run the third workday of each month reporting for the previous month.

Regional office staff are to review these reports on a monthly basis.

Mike Robinson, Commissioner

~~Volume I~~
~~The following manual sections are cross-referenced with this update: MS 1630, MS 1631, MS 1648 and MS 1865.~~
Volume II
The following manual sections are cross-referenced with this update: MS 8200, MS 8210 and MS 8220.

Volume III
The following manual sections are cross-referenced with this update: ~~MS 2011~~ and MS 2877

MS 99680 IM CERTIFICATION PERIOD CHANGE

See OMTL-329, 4/1/09
See OMTL-294, 6/1/08

In order to provide for more efficient program administration and consistency between FS and IM cases, effective 11/1/04 all IM case approvals will now have a 12-month certification period, that starts with the application month. The count will begin with the month of application, instead of the month of approval. Program codes impacted are C, E, F, G, H, I, J, K, KC, L, M, N, P, S, T, U, W, X, Y and Z. Exception: This change will not effect the QI1 cases, which are always assigned a certification period through the end of the calendar year.

For cases on the PA-62 system, workers are not to assign a certification period longer than 12 months.

Example: An application or program transfer taken in August, but not approved until September, will have a certification period through July 31st of the following year.

For State Supplementation cases (FP, GP and HP) the certification period will be 24 months from the month of application or program transfer. The 12-month review period will also follow this change.

Example: An application or program transfer taken in November of the current year will have a 12-month review to be conducted in October of the following year with the 24-month recertification to be completed in October of the 2nd year following the year of application.

It is not necessary to convert any existing IM cases to the new certification standards. Workers will still retain the ability to shorten the certification period if necessary. If a joint (JT) application is entered on KAMES, the certification periods automatically assigned by KAMES at disposition should match for a PAFS/K-TAP household. Staff are to review the dates assigned by the system prior to disposition to ensure PAFS/K-TAP households requiring a joint interview are assigned correctly.

Mike Robinson, Commissioner

Volume II
The following manual section has been cross-referenced with this update: MS 6103
Volume III
The following manual sections have been cross-referenced with this update: ~~MS 2017~~, ~~MS 2038~~ and MS 5100

~~Volume IV~~
~~The following manual section has been cross-referenced with this update:~~ ~~MS 1550~~
~~Volume IVA~~
~~The following manual sections have been cross-referenced with this update:~~ ~~MS 1480 and MS 4940.~~
~~Volume VI~~
~~The following manual section has been cross-referenced with this update:~~ ~~MS 4155~~

MS 99677 NEW REFERRAL PROCESS FOR DVR

Effective 7/1/04, Kentucky Works Program (KWP) participants identified as needing services from the Department for Vocational Rehabilitation (DVR) are to be referred to DVR using a new component code, RHB, on STEP. This component is a direct referral provider type "N" component and is considered an allowable, not countable, activity.

It is extremely important for staff to assess every K-TAP recipient and his/her ability to participate in KWP activities. The only individuals who are exempt from participating in KWP activities are those with a child under 12 months of age, for a maximum of 12 months in a lifetime and teen parents with a child under 12 weeks of age. All other recipients are subject to participation in KWP. Individuals with disabilities and/or barriers are to be provided the same opportunity to participate in programs under the Americans with Disabilities Act of 1990 (ADA). Do not assume an individual with a disability does not want to participate. When assessing participants, complete form KW-200A, Assessment Supplement.

With the implementation of this component it is no longer necessary to complete hard copy referral forms to be forwarded to DVR. Utilizing the RHB component code will automate the referral process and STEP will send forms KW-105, Referral Form (Participant) and KW-105A, Referral Form (Provider), to the appropriate DVR regional office for each county as identified by DVR staff. Please go to the link for a list of referral codes for each county. Use the code listed for your county when making a referral to DVR.

http://cfc.ky.gov/dcbs_manuals/DFS/miscellaneous/DVR.doc

As with all other allowable, not countable activities, participation in the RHB component must now be tracked. Once an individual is placed in this component code, STEP will generate form PA-33, Verification of Education/Training and Transportation, to the participant each month. An individual who has signed a Transitional Assistance Agreement (TAA) indicating he/she will cooperate with DVR and then fails to follow through is subject to conciliation. Individuals approved for K-TAP or allowed good cause for KWP based upon a conditional incapacity determination from the Medical Review Team (MRT) may need to be referred to DVR for assistance if form PA-6, Incapacity Determination, indicates cooperation with DVR would be beneficial to the client. Ensure this activity is noted on the TAA.

Mike Robinson, Commissioner

Volume IIIA
The following manual sections have been cross-referenced with this update: MS 4035, MS 4130, MS 4375, MS 4520, MS 4540, MS 4550, MS 4560, MS 4600, and MS 4650.

MS 99674 JOINT CUSTODY

See Errata To: OM Update No. 04-20, MS 99674E, 7/1/04.

Effective 7/1/04 joint custody policy is revised.

A. For K-TAP and Family MA, the application of joint custody policy is no longer limited to applicants/recipients who are legally separated or divorced. This change in policy now extends to joint custody orders for the parents of the child regardless of their previous marital status. This includes parents of a child who were never married but have been established as the legal parent either administratively or by adjudication.

1. If parental support is being maintained by the absent parent according to the joint or shared custody order and is well documented, deprivation of the child due to absence of a parent is not established. Continued absence DOES NOT exist if the following is true regardless of the amount of time spent in each parent's home.
   a. Absence is not of a continuous nature, and both parents continue to exercise their parental functioning.
   b. On a regular, at minimum, monthly basis, the parents are making decisions and arrangements in the child's best interest.
   c. There is an ongoing, continuing relationship between the child and the parents with both parents involved in providing parental support and care.

Example 1: A mother applies for assistance alleging a deprivation for the child due to absence of the child's father. A court document indicates joint custody but the mother indicates the father does not share physical custody of the child. The child visits with the father on a monthly basis as ordered by the court. The father lives out of county but makes weekly phone contact with the child. He attends parent/teacher conferences and participates in the child's activities regularly. School records indicate he can pick the child up at school and has done so frequently. Child support is paid faithfully by the father and his health insurance at work includes the child. The mother does agree that these circumstances are correct. Deprivation due to absence of the father does not exist in this case as the child IS NOT deprived of parental support.

Example 2: A parent applies for assistance alleging deprivation for the child. Joint or shared custody is indicated in a court document. The child lives with each parent an equal amount of time each month, alternating regularly between each parent every two weeks. The parent, with whom the child is staying at the time, makes

decisions concerning the child's activities at home, doctor visits, and participation in school functions. Continued absence does not exist for either parent since the child maintains regular and equal contact with both parents on an, at minimum, monthly basis, and is not deprived of support by either parent.

Example 3: A mother of a child applies for assistance alleging absence of the father. She indicates she was never married to the child's father but paternity was established administratively. A court document shows joint or shared custody by both parents on a weekly basis. The child's father lives with his mother who babysits the child while the father works part-time. He cares for the child while not at work and fulfills scheduled doctor visits while the child is in his care. In this situation, the child is not deprived of support by either parent and eligibility for K-TAP is not established.

2. If a court document indicates custody is to be equally shared but evidence indicates this is not being met, a parent who is currently a recipient or who is applying for K-TAP may be eligible for benefits if deprivation of the child by absence of a parent is established. Documentation used to verify the parent is not maintaining custody at the level ordered by the court can include collateral contacts and/or written records kept by a parent. Family Support may contact the absent parent to obtain information which may counter the applicant's contention of deprivation. The worker must establish if the parent for whom absence is indicated is depriving the child of parental support.

   Example: A father applies for assistance alleging deprivation for the child through continued absence of the mother. A court document indicates joint or shared custody but the father indicates the mother seldom has the child with her. The mother has moved into a one bedroom apartment with her boyfriend and records show she does not participate in any of the child's activities, such as the child's parent/teacher conferences, PTA, etc. The joint or shared custody order requires the child live with the mother half of the time each month, but it is well documented that the child stays exclusively with the father. In this situation, though a court document indicates joint or shared custody, absence of the mother is of a continuous nature and deprivation exists.

3. A parent, who is applying for or receiving K-TAP or Family MA (when deprivation is a factor), is maintaining primary physical custody of the child and indicates a joint custody order exists, may be eligible for K-TAP or Family MA, if all other eligibility criteria are met. The parent, with primary physical custody, makes the decisions pertaining to the child. The K-TAP or Family MA case remains eligible during periods when the child may be with the other parent who does not have

primary physical custody and is not involved in decision making for the child.

Example: A mother and children receive K-TAP. A joint custody order exists. The mother has primary physical custody of the children but the father has the children during their summer break from school. Though the father has responsibility of the children during this period of several months, the mother continues to receive K-TAP for the period as she maintains parental control of the children.

B. Based on a legal opinion, when an application for Kinship Care (KC) is made and a joint or shared custody order exists for caregiver relatives of the child who live separately, there can be no KC case.

1. In determining eligibility for KC, permanency of the child is considered at risk if the potential for the child moving between separate residences of relatives exists. For the applicant in this situation to receive KC, an amended custody order by the court would be necessary.
   a. If the caregiver relative indicates he/she wishes to continue the KC process and will pursue an amended custody order through the court system, pend the KC application for up to 30 days.
   b. If, within the 30-day period, an indication of a new court order is forthcoming, continue to pend the application to allow for approval of KC with receipt of the new court order.
   c. Discuss with the caregiver the option that K-TAP eligibility may be established if an amended court order is not pursued.

Example 1: An aunt of a child applies for Kinship Care and indicates a joint custody order exists. The aunt cares for the child in her home but the child's maternal grandmother is also included on the joint custody order. The grandmother does not live with the aunt and child. The order allows the grandmother to have the child in her home at times throughout the month. As the order allows for the child to be moved between the two caregiver relatives, the child's permanency is at risk. In this situation, KC is not allowed.

Example 2: In the above example the aunt indicates that she feels the grandmother will agree to an amendment of the joint custody order to allow the aunt to have sole custody of the child so that KC is possible. The aunt indicates she will take action in court immediately to have the custody order changed. The KC application is pended to allow for the change in the custody order.

2. If both parties of a joint custody order, who are the child's caregiver relatives, live in the same home, an exception to this rule is possible. A determination of eligibility under these circumstances is made on a case-by-case basis.

Example: The aunt and uncle of the child live together and apply for KC on behalf of the child. A court order exists and lists both aunt and uncle for joint custody. In this situation, KC may be possible as permanency of the child is not at risk. A decision would be required of the two caregiver relatives to determine which relative would be listed as the KC caregiver on the KC application.

3. There can be no KC case if a joint custody order lists a parent of the child for whom KC is pursued, whether the parent lives in the home with the caregiver relative or elsewhere.

A desk review of cases is not required. Make changes as necessary through normal case action.

Mike Robinson, Commissioner

Volume III
The following manual sections have been cross-referenced with this update: MS 2340, MS 2355 and MS 2367.
~~Volume IV~~
~~The following manual sections have been cross-referenced with this update~~: ~~MS 1050, MS 2200, MS 2530, and MS 2560~~.

MS 99672 UTILITY ALLOWANCE REVISIONS

The annual revisions of the Standard Utility Allowance (SUA) and Basic Utility Allowance (BUA) are as follows:

There is only one SUA and one BUA amount regardless of household size.

A. The SUA for all households that incur a heating or cooling cost is $260.

B. The BUA for all households who incur at least two utility expenses which are non-heating and non-cooling (a telephone expense can be one of the two expenses) is $190.

C. The telephone standard is $32.

Mike Robinson, Commissioner

Volume II
The following manual sections have been cross-referenced with this update: MS 5495, MS 5498 and MS 5500.

MS 99671 KINSHIP CARE DISCONTINUANCE CODE

Individuals receiving Kinship Care benefits must agree to pursue permanent custody of a child. It is imperative to ensure the Kinship caregiver is aware of this requirement. Caregivers must be prepared to verify permanent custody is obtained or that it is being pursued within the next 12 months. A review date field has been added to the system that will identify the month in which verification or pursuit of permanency is required. Remind caregivers that their Protection and Permanency (P & P) worker can assist them with this process.

In order to track cases that are discontinued for failure to obtain permanent custody, a new discontinuance code has been added to KAMES. This discontinuance code is only valid after 12 months of receipt of Kinship Care.

I. Two new questions are being added to KAMES effective 5/3/04 to assist with tracking permanent custody and ensure that cases failing to meet this requirement are discontinued with the appropriate reason code. The KAMES system will take action on Kinship Care cases based upon the responses entered in these two fields.

A. The two new questions are:

1. “Has permanent custody been obtained? __ Ver Src __ Date __”; and

2. “If ‘N’ has it been pursued? ___ Rev date __ Ver Src __ Date __”.

B. Valid entries for responses are:

1. "Y" for Yes and "N" for No.

2. Verification source field:

a. OR for original record;
b. WS for written statement; and
c. CC for collateral contact.

3. The review date must equal the last day of certification or the last day of the twelve month period. If staff enter a past date or a current month date, the error message "Date must be a future date" will appear.

C. The questions will appear for each member coded as a child on the case and must be answered based upon the individual circumstances of each child.

II. For applications effective 5/3/04 and later:

A. If the response to "Has permanent custody been obtained?" is yes:

1. The individual has documentation, enter the appropriate verification source code. No further action is needed.
2. If the individual has permanent custody, but does not have verification, answer “N” to both questions and enter a review date for the last day of the month in which the case is due for recertification. Verification of permanency is not required, prior to the 12th month of receipt of Kinship Care.

B. If the response to "Has permanent custody been obtained?" is no, and the response to "If 'N' has it been pursued?" is no, enter a review date for the last day of the month in which the case is due for recertification. If no review date is entered, the system will discontinue the case. Advise the caregiver that verification of permanent custody or verification of pursuit of permanent custody must be provided at next recertification (12 months).

Example: A child is placed with a caregiver in February 04. We receive form KIM-78KC, Kinship Care Financial Assistance Application, on 4/23/04. We enter the application on the system the same date. The caregiver completes the application process on 5/2/04. The certification period assigned by the system is 4/1/04 to 5/31/05. The review date entered on the system is the last day of the month in which the case will be due a recertification, 5/31/05.

C. In the month prior to recertification, Family Support staff will receive a spot check on the last day of the month prior to the review date to remind them to question the caregiver about permanency. (In the example above, the spot check would appear on 4/30/05).

1. P & P staff are required to maintain an open case until permanency is achieved. Send form PAFS-628, Exchange of Information, to P & P staff to let them know that the caregiver is now required to provide verification of permanency or the pursuit of permanency.
2. Family Support staff may ask P & P staff to provide verification of permanency, if permanency is already obtained.

D. If, at recertification, the caregiver states that permanency has not been established or is being pursued, answer “N” to both questions. Leave the original review date in the review field. In order to meet the definition of pursuing permanent custody, the caregiver must verify he/she has hired an attorney or has petitioned the court.

1. If verification of permanency is not received within 10 days (RFI date), the system will take action to discontinue the case.

    a. Advise the caregiver if verification of permanent custody or the pursuit of permanent custody is not provided, Kinship Care eligibility will be lost. However, eligibility for K-TAP and Medical Assistance can be pursued. The system will not automatically establish ongoing eligibility for a child removed from a Kinship Care case.
    b. If a caregiver makes contact regarding the discontinuance of Kinship Care benefits, schedule the caregiver an appointment to determine

eligibility for K-TAP. The date of eligibility for K-TAP is the date the caregiver comes in to the office to apply.

2. If verification of permanency is received, update the verification source field on the system. No further action regarding permanency is required.

E. If the caregiver states permanent custody is obtained or is being pursued, he/she must provide verification.

1. If "Y" is answered to the 2nd question, a review date is not necessary.
2. The system will pend the case and a RFI will print allowing the caregiver 10 days to return the verification.
3. If verification is received within the 10 day timeframe, update the verification source field on KAMES. No further action regarding permanency is required.
4. If verification is not received in a timely manner, the case will discontinue.
5. The caregiver will no longer qualify for Kinship Care benefits. The child may qualify for K-TAP and/or Medical Assistance. The caregiver must apply for K-TAP.

III. For recertifications completed May, June and July 2004, caregivers are given an additional 12 months to provide verification of permanent custody, if it has not already been obtained.

A. At current recertification, review form KC-14, Kinship Care Rights and Responsibilities, and stress to the caregiver the importance of ensuring permanent custody is pursued and/or obtained by his/her next recertification.

B. Enter a review date on the system for the last day of the month in which the case is due for recertification.

C. At the next recertification, do not change the review date. Follow the steps outlined in Section II D.

IV. For recertifications completed August 1, 2004 and thereafter.

A. Caregivers must provide verification that permanent custody has been pursued. Forms KC-14, and KC-01, KCP Statement of Rights and Responsibilities, were effective 8/1/03 and informed caregivers of their responsibility to pursue permanent custody.

B. If, at recertification, the caregiver states that permanency has been obtained and has verification, enter the appropriate verification source. No further action regarding permanency is required.

C. If, at recertification, the caregiver states that permanency has not been obtained or pursued, enter a review date for the last day of the following month.

1. Inform the caregiver to contact his/her P & P worker if assistance is needed for the permanency process.

2. Send form PAFS-628 to P & P staff to advise that the caregiver is now required to provide verification of permanency and that the case will discontinue in 10 days if verification is not received.

3. If verification of permanency is received in a timely manner, update the verification source field on KAMES. No further action regarding permanency is required.

4. If verification of permanency is not received in a timely manner, the system will take action to discontinue the case. Ongoing eligibility for Kinship Care benefits is lost. Explore eligibility for K-TAP and/or Medical Assistance.

D. If, at recertification, the caregiver states that permanency has been obtained but does not have verification, leave the verification source field blank.

1. If verification of permanency is received in a timely manner, update the verification source field on KAMES. No further action regarding permanency is required.

2. If verification of permanency is not received in a timely manner, the system will take action to discontinue the case within 10 days (RFI date).

Example: A caregiver is due a recertification in August 2005. There will be no review date on the system at recertification. One must be entered if the caregiver states permanency has not yet been pursued. Enter a review date of 9/30/05. If verification is not received within 10 days (RFI date), the system will discontinue the case.

3. Kinship Care eligibility is lost. Explore eligibility for K-TAP and Medical Assistance.

V. If a child is added to an established Kinship Care case, the review date entered on the system is 12 months from the date the child is entered on KAMES as a member of the case. This may be more than 12 months from the date the child was placed with the caregiver.

A. Staff will receive a spot check on the last workday of the month prior to the review date. As this review date is not likely to correspond with the recertification period, send the caregiver form PAFS-2, Application Letter or Notice of Expiration, requesting verification of permanency and scheduling an appointment to discuss permanency.

B. Follow the steps outlined in Section II D. Update the response to Kinship Care permanency questions via case change.

C. Based upon the exception to Standard Filing Unit, it is possible for a child to be removed from a case for failure to provide verification of permanency and have the case ongoing eligible for other children in the home, provided all other eligibility criteria is met.

D. The system will not automatically establish ongoing eligibility for a child removed from a Kinship Care case.

1. Review ongoing eligibility for Medical Assistance.

2. If a caregiver makes contact regarding the discontinuance of Kinship Care benefits, schedule the client an appointment to determine eligibility for K-TAP. The date of eligibility for K-TAP is the date the client comes in to the office to apply.

VI. If a caregiver provides verification that permanent custody was denied, no further action is required. It is not a requirement that permanent custody be obtained. The judicial system will sometimes deny a request for permanent custody against the recommendation of P & P staff and caregivers are not penalized in this situation. Request documentation from the caregiver or P & P staff and update KAMES comments to indicate the caregiver's attempt at permanency failed. No further action is needed.

VII. Caregivers who lose Kinship Care eligibility due to failure to pursue permanent custody timely are not eligible for reinstatement of Kinship Care benefits. The discontinuance reason code for failing to verify permanency is 706. The member status code is 906. If the caregiver comes in to reapply for monetary assistance, explore eligibility for K-TAP.

Mike Robinson, Commissioner

Volume III
The following manual sections have been cross-referenced with this update: MS 5030 and MS 5100.

MS 99670 UP COUNTABLE PARTICIPATION

See OMTL-329, 4/1/09

This is to clarify how the hours of participation for Unemployed Parent (UP) cases are counted toward the Federal participation rate for both the "C", “all-family” (HRSTEPN88 report), and "W", "two-parent" (HRSTEPN89 report) categories.

There is no change in the Federal calculation process of participation rates for UP cases. This update clarifies that it is beneficial for UP cases to meet Federal participation rates for the “C”, “all-families” rate, as well as the “W”, “two-parent” rate. A UP case is counted in the denominator for both the “two-parent” and “all-families” rate and affects the Federal participation rate in both categories. The denominator is the total number of cases with an adult requiring mandatory participation in the Kentucky Works Program. The only time a UP case is excluded from the denominator or numerator for the “two-parent” or “all-families” rate would be for the first 3 months of a sanction if both parents are sanctioned.

A. For a UP case to meet Federal participation for the “all-family” rate, one parent must participate an average of 30 hours weekly per month of participation from core work activities. The hours of participation cannot be shared between the two parents for the “all-family” rate.

B. To meet the “two-parent" rate, one parent or a combination of both parents are required to participate in work activities for:

   1. 35 hours of participation per week if not receiving Federally-funded childcare. At least 30 of the 35 hours must be from participation in core work activities.

   2. 55 hours of participation per week if receiving Federally-funded childcare. At least 50 of the 55 hours must be from participation in core work activities.

C. The core activities that one parent must participate satisfactorily in to count in the “all-family” rate are:

   1. Unsubsidized employment;

   2. Subsidized private sector employment;

   3. Subsidized public sector employment;

   4. Work experience;

   5. On-the-job training (OJT);

6. Job search and job readiness assistance;

7. Community service programs:

8. Vocational educational training; and

9. Providing childcare services to an individual who is participating in a community service program.

D. If the parent(s) meet the work requirement for core activities of 30/50 hours per week, countable hours may also come from work activities:

1. Job skills training directly related to employment;

2. Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency; and

3. Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalency, if a recipient has not completed secondary school or received such a certificate.

EXAMPLE: A UP case is receiving no Federally-funded childcare and one parent is employed an average of 40 hours per week. The 40 hours of employment per week will meet the 30 hours in core activities requirement for one parent. This is countable participation on both the HRSTEPN88 and HRSTEPN89 reports.

EXAMPLE: A UP case receives Federally-funded childcare. One parent is working 30 hours per week and the other parent is working 35 hours per week. The sum of hours per week for the two parents is greater than 55 hours per week with both meeting the 30 hours in core activities requirement. This is countable participation on both the HRSTEPN88 and the HRSTEPN89 report.

EXAMPLE: A UP case receiving no Federally-funded childcare and both parents are working an average of 25 hours per week for a total of 50 hours per week. As one parent is not meeting the 30 hours of core activities requirement, the case is countable on the HRSTEPN89 (UP rate) report but not on the HRSTEPN88 (all-families) report.

EXAMPLE: A UP case receives Federally-funded childcare. One parent is employed 35 hours per week and one is employed 15 hours per week. The family is countable on the HRSTEPN88 report, as one parent is meeting 30 hours of core activities, but is not countable on the HRSTEPN89 report as the 55-hour requirement is not being met.

EXAMPLE: A UP case receives Federally-funded childcare to allow both parents to participate. One parent is working 25 hours per week. The family is not countable on the HRSTEPN88 report because neither parent

is meeting the 30 hour requirement. The family is not countable on the HRSTEPN89 report as the 55-hour requirement is not being met.

E. If either parent misses any scheduled time from the KWP activity, the time must be made up sometime during the month. A monthly average of the required hours per week is used to determine the participation rate.

F. It is most advantageous to enter participants into components at the first of every month. Many components, such as JRA, WEP, and GJS, are time limited. If entered after the first of the month, tracking will have to be completed with a "N" for that month for not meeting participation as the hours of participation are not being fulfilled for the Federal participation rate.

EXAMPLE: An individual applies on the 15th of the month. An assessment is completed and the client wants to enter a WEP position. Have all forms completed and set up the WEP position during the latter part of the month. If the client cooperates with this process, he/she would be considered as cooperating with KWP and conciliation or sanction would not be appropriate. The client should begin the WEP position on the 1st of the next month, and if required hours of participation are met, tracking is completed with a "Y" for meeting participation rates and would be countable in Federal participation rates.

Mike Robinson, Commissioner

Volume IIIA
The following manual sections have been cross-referenced with this update: ~~MS 4000~~, ~~MS 4600~~ and MS 4800

MS 99661 CHANGES IN SPECIAL CIRCUMSTANCE PROCESSING

See OMTL-329, 4/1/09
See OMTL-294, 6/1/08

Effective 2/1/04, the following changes are in effect for processing Special Circumstance actions on KAMES. It is important that you note how the terms supervisor and principal, as listed below, apply to individuals coded with KAMES security clearance type 02 (supervisors) and type 24 (principals). These are the people with clearance to sign off on an action. It does not refer to an individual's personnel classification.

A. All special circumstance actions will continue to pend for supervisory approval but capability to "sign off over the shoulder" is removed.

1. When an individual initiates a special circumstance action, the system no longer provides fields for entry of supervisor or principal worker codes on the screen at the end of the action. Instead, the message "action pending – take case to supervisor" appears. This includes actions initiated by principals. A principal worker is no longer able to sign off on his/her own special circumstance action transaction.

2. The case file must be taken to the principal, supervisor, or designated individual, as appropriate, for a separate sign off. In order to successfully sign off on a case, the supervisor, principal, or designated individual must be logged on to KAMES in his/her own "HRII" code.

3. If the special circumstance action is not signed off on appropriately on the same date the action is initiated, the worker and supervisor will receive a DCSR message "Awaiting Aprvl – Spec Circum" the next work day as a reminder the action has pended.

4. Supervisors can not update or change any data on a pending special circumstance transaction. Any needed changes must be given back to the worker initiating the action for corrections before the payment is approved.

B. Supervisors can no longer initiate a special circumstance transaction. If a supervisor attempts to enter "Y" to the "Do you wish to add a selection not listed above?" on the special circumstance (HRKIPDIE) screen, the error message "Entry not allowed" will be posted.

C. Supervisors and principals have a new option on the KAMES Daily Case Status Report Menu (HRKIMU57) screen. The new option is "O – Special Circumstance Approved". The system takes the worker to this screen as they page through the DCSR screens at sign on or the worker can manually select option "O" to view at any time. When viewed, this listing will provide information on all special circumstance actions approved using that individual's HRII code and password.

1. The actions will remain on the listing for 14 calendar days from the approval date and cannot be deleted or removed.

2. The listing indicates the type of special circumstance transaction completed as follows:

    a. Education bonus;
    b. Money payments;
    c. Medical cards; and
    d. Lock-in.

Supervisory, principal, and designated workers are advised to view the listing on a daily basis for any discrepancies. If any payments on the listing were not authorized by the individual indicated, report the information immediately to the appropriate regional staff for investigation.

Mike Fields, Deputy Commissioner

INSTRUCTIONS FOR OPERATION MANUAL MAINTENANCE
PEN AND INK CHANGE(S)
VOLUME I
Cross-reference the following with: "OM Upd. No. 04-09, MS 99661, 2/1/04". Page 0457-0458 (R. 11/1/98), MS 0458
VOLUME III
Cross-reference the following with: "OM Upd. No. 04-09, MS 99661, 2/1/04". ~~Page 2053-2055 (R. 3/1/99), MS 2055~~ ~~Page 2060 (R. 3/1/99), MS 2060~~ Page 3700 (R. 6/1/03), MS 3700
~~VOLUME IV~~
~~Cross-reference the following with: "OM Upd. No. 04-09, MS 99661, 2/1/04".~~ ~~Page 2070-2080 (8/1/96), MS 2070~~ ~~Page 2640 (R. 9/1/00), MS 2640~~ ~~Page 2690 (R. 11/1/98), MS 2690~~ ~~Page 2710 (R. 11/1/98), MS 2710~~ ~~Page 2810 (8/1/96), MS 2810~~ ~~Page 2872-2880 (R. 11/1/98), MS 2880~~
~~VOLUME IVA~~
~~Cross-reference the following with: "OM Upd. No. 04-09, MS 99661, 2/1/04".~~ ~~Page 2730-2740 (R. 1/1/99), MS 2740~~ ~~Page 4500 (8/1/96), MS 4500~~ ~~Page 4595 (R. 9/1/00), MS 4595~~

INSTRUCTIONS FOR OPERATION MANUAL MAINTENANCE (CONT)		
PEN AND INK CHANGE(S)		
VOLUME VI		
Cross-reference the following with: “OM Upd. No. 04-09, MS 99661, 2/1/04”. Page 4060-4062 (R. 5/1/97), MS 4062 Page 4070-4080 (R. 10/1/97), MS 4080 Page 5450 (R. 8/1/98), MS 5450 Page 5460 (R. 12/1/98), MS 5460		
VOLUME X		
REMOVE AND DESTROY	INSERT	
	99661(1) 99661(2)	2/1/04 2/1/04
	99661(3) 99661(4)	2/1/04 2/1/04

MS 99638 KINSHIP CARE

Effective 8/1/03, the following revisions and clarifications to the Kinship Care Program are in place. To the extent funds are available, Kinship Care is an alternative to Foster Care and provides a permanent placement for a child who is or would otherwise be placed in Foster Care due to abuse, neglect, or death of both parents. Income limits for the child remain unchanged.

A. A child is considered for Kinship Care if Protection and Permanency (P&P) staff determines that the child is at risk of removal from the home and would otherwise be placed in Foster Care, or is in the custody of the Cabinet and residing in Foster Care due to:

1. A Cabinet investigation that resulted in a substantiation of abuse or neglect within 120 calendar days of placement in the home of the caretaker relative; or
2. The death of both parents.

B. The Kinship Care caretaker is the qualified nonparental relative of a child with whom the child is placed by P&P staff, as an alternative to Foster Care. Effective August 1, 2003, all potential Kinship Care Program recipients must undergo an initial eligibility process conducted by P&P staff before Family Support staff can determine the child's eligibility for financial benefits under Kinship Care. To satisfactorily complete the initial eligibility determination, a caretaker relative of a child and all members of the household shall meet the following requirements:

1. Achieve a satisfactory relative home evaluation;
2. Meet approval criteria established for criminal records checks;
3. Meet approval criteria for child abuse and neglect checks, conducted by P&P staff; and
4. The Kinship Care caretaker relative must agree to and sign the form KC-01, Kinship Care Program Statement of Rights and Responsibilities.

C. A child is considered for Kinship Care if the child is placed with a caretaker relative in Kentucky by another state via the Interstate Compact for the Placement of Children (ICPC) and the Cabinet receives from the other state agency responsible for the child's placement verification of:

1. A finding of substantiated abuse or neglect within 120 calendar days of the child's placement, as determined by the state agency responsible for the child's placement; or
2. The death of both parents.

D. The child is considered placed with a caretaker relative in another state for Kinship Care if the:

1. Child and caretaker relative become a resident of Kentucky within 45 calendar days of the child's placement;

2. Caretaker relative applies for Kinship Care within 45 calendar days of the child's placement; and
3. Other state agency responsible for the child's placement provides verification that the placement was due to:
   a. A finding of substantiated abuse or neglect within 120 days of the child's placement, as determined by the state agency responsible for the child's placement; or
   b. Death of both parents.

E. The child's designated P&P worker uses form KIM-78KC, Kinship Care Financial Assistance Application, to refer the Kinship Care caretaker relative and child to Family Support staff for an eligibility determination for Kinship Care financial benefits for the child. Prior to sending form KIM-78KC to Family Support, the form is signed and dated by:

1. The designated P&P worker assigned to the child; and
2. The caretaker relative with whom the child is placed; or
3. A representative authorized in writing to act on behalf of the caretaker relative.

The caretaker relative undergoes initial eligibility determination and determination of eligibility for financial benefits under the Kinship Care Program, regardless of whether or not the caretaker relative received Kinship Care benefits in another State.

F. To complete the referral of the caretaker relative to Family Support for consideration of financial assistance under Kinship Care, P&P staff forwards within 3 work days the following to Family Support:

1. The completed and signed KIM-78KC;
2. A copy of the signed KC-01;
3. Written verification from P&P staff that the child and the caretaker relative have met initial eligibility criteria; and
4. Any additional documentation which may be pertinent in determining eligibility for financial assistance under the Kinship Care Program. This does not include a copy of the home evaluation. It will remain in the P&P case file.

Upon receipt of form KIM-78KC, Family Support staff must send the caretaker relative an appointment letter to schedule an appointment to compete the interview.

G. The date of application for benefits on form KIM-78KC is the date the child is placed in the home. The P&P investigation, home evaluation, records check, etc., are done in the county in which the child resides. The application for financial benefits is processed in the county of residence of the caretaker relative. If the caretaker relative is unable to go to the local Family Support office to complete the application process, the caretaker relative may:

1. Designate an authorized representative; or
2. Request a home visit.

H. If all technical and financial eligibility factors are met, the effective date of eligibility for Kinship Care benefits is the date of placement of the child in the home of the Kinship Care caretaker relative that is listed on form KIM-78KC. However, a child is not eligible for Kinship Care if the:

1. Form KIM-78KC is not signed by the P&P worker designated to monitor the child's permanency, safety, and well being;
2. Child receiving Kinship Care benefits does not have a designated P&P worker to monitor the child's permanency, safety, and well being, unless the Kinship Care caretaker relative has obtained or pursued to the extent possible permanent custody of the child;
3. Prospective caretaker relative of a child declines the initial offer of Kinship Care benefits by signing form KC-01, Kinship Care Program Statement of Rights and Responsibilities;
4. Child or caretaker relative lives in or relocates to another state;
5. Child's removal is based on a Cabinet finding of dependency, except for a finding of dependency based on the death of both parents of the child;
6. Child no longer meets the definition of a child; or
7. Child's parent resides or moves in with the Kinship Care caretaker relative. If the parent is in the home, notify the child's P&P worker and discontinue the child's Kinship Care case.

I. A decision is made regarding eligibility for Kinship Care benefits and a payment issued within 30 calendar days of the date form KIM-78KC is signed by the caretaker relative or representative. An exception to this time standard may be provided if the caretaker relative or Cabinet requires additional time to obtain verification necessary for an eligibility determination. The Kinship Care application can be pended over 30 days on KAMES if it is necessary to assist the Kinship Care caretaker relative with needed verification or information. Because of the difference between the application date and the date form KIM-78KC is received by Family Support, Kinship Care cases may exceed the 30-day time standards and show past due on reports. However, Kinship Care cases are not past due unless they exceed 30 days beyond the date form KIM-78KC is signed. Document the case if the timeframe is not met and why.

J. P&P staff will recommend to the court that the Kinship Care caretaker relative be granted temporary custody of the child, and the caretaker relative must agree to take temporary custody of the child. A judicial authority failing to grant temporary custody to the Kinship Care caretaker relative cannot be used to deny the caretaker relative's application for Kinship Care.

K. P&P staff will provide services or facilitate access to services, including case-management services, for at least 6 months beginning with the date of placement of the child with the caretaker relative or until the caretaker relative has permanent custody of the child.

The child's designated P&P worker will develop a case permanency plan and conduct regular visits with the child. Prior to the 12th month of placement into the Kinship Care caretaker relative's home the P&P worker will:

1. Review the case permanency plan and placement to determine if kinship care is in the best interest of the child;
2. Prepare a court report recommendation pertaining to permanent custody of the child; and
3. Request that the case be redocketed for court action to determine permanent custody, if appropriate.
4. To the extent funds are available, the following services may be provided by P&P staff as needed on a case-by-case basis to insure a placement is not disrupted:
   a. Respite care;
   b. Family counseling;
   c. Parenting training; or
   d. Referral to an available support group.

L. To continue receiving Kinship Care benefits, the Kinship Care caretaker relative must pursue permanent custody of the child.

1. Permanent custody of the child is considered pursued, if a petition for permanent custody of the child is filed no later than 30 calendar days after the 12th month of:
   a. Receiving financial assistance from the Kinship Care Program; or
   b. Signing form KC-14, Kinship Care Rights and Responsibilities.
2. Form KC-14 is mandatory for all Kinship Care caretaker relatives completing a recertification interview beginning August 1, 2003, and ending July 31, 2004. Form KC-14 is not required for applications taken August 1, 2003, and thereafter, as P&P staff will cover the Kinship Care caretaker relative's rights and responsibilities at application utilizing form KC-01.
   a. Form KC-14 is completed at recertification to ensure that current caretaker relatives understand their responsibilities. Specifically the responsibilities of pursuing permanent custody, if not already obtained, within 12 months and cooperating with the recertification process every 12 months.
   b. Cooperating with the recertification process is uniquely important for Kinship Care cases as eligibility may be lost if the recertification appointment is not kept. It is extremely important that this information is conveyed to the Kinship Care caretaker relative at application and recertification.
   c. Form PAFS-628 is forwarded to P&P staff if permanent custody is not already obtained. A copy of form KC-14 is attached to form PAFS-628. P&P staff may provide the Kinship Care caretaker relative information about obtaining permanent custody. Funds to be used for start-up costs may be used for attorney's fees to obtain permanent custody. However, the responsibility and expense of pursuing permanent custody belongs to the Kinship Care caretaker relative, not the Cabinet.
   d. Form PAFS-628 is forwarded to P&P staff along with the attached form KC-14 if the Kinship Care caretaker relative chooses not to sign form KC-14. P&P staff are advised on form PAFS-628 the effective date of discontinuance of the Kinship Care case.
   3. For applications accepted and approved on or after 8/1/03, at recertification, if permanency is not established:

a. Notify P&P that permanency is not established using form PAFS-628; and
b. Spot check the case 30 days after completing the Kinship Care recertification.

When completing the contact for the 30-day spot check:
(1) If a petition of permanent custody has been filed, no action is necessary.
(2) If a petition of permanent custody has not been filed, discontinue the Kinship Care case. Notify P&P staff that the Kinship Care case is discontinued using form PAFS-628. Advise the Kinship Care provider that an application for K-TAP for the child may be taken.

M. Eligibility may follow the child in some circumstances. The initial finding of substantiated abuse or neglect of the child may be used for a reapplication and redetermination of eligibility for financial assistance under the Kinship Care Program for the following reasons.

1. A child who is discontinued from Kinship Care due to SSI eligibility subsequently becomes ineligible for SSI.
2. The child leaves the home of the Kinship Care caretaker relative and the Cabinet places the child with another caretaker relative due to:
   a. Death of the Kinship Care caretaker relative;
   b. An illness or injury of the Kinship Care caretaker relative, as supported by medical documentation, that inhibits adequate care of the child; or
   c. Active duty in military service of the Kinship Care caretaker relative.
3. The child is returned to the Kinship Care caretaker relative if the absence is temporary for a period of 30 consecutive calendar days or more due to medical care or school attendance and the child continued to be under the care and control of the Kinship Care caretaker relative.
4. Kinship Care benefits may be temporarily stopped during the time the child is residing in:
   a. Foster Care;
   b. A residential treatment facility;
   c. A psychiatric residential treatment facility;
   d. A parent's home for up to 60 days for reunification purposes on a trial basis; or
   e. Detention in a juvenile facility.

N. The maximum monthly payment scale and child's income limit is unchanged.

O. P&P staff issues an eligible start-up cost payment by check directly to a vendor providing the needed service or item. To the extent funds are available, a one-time start-up amount may be provided for the purpose of supplying a child's immediate need for:

1. Clothing;
2. School supplies;
3. Additional furniture;

4. A deposit for a larger apartment; and
5. An essential cost (documented in the case record) up to the maximum allowed including attorney fees if needed by the Kinship Care caretaker relative in obtaining permanent custody of the child.

The total amount of assistance allowed for the Kinship Care case for start-up costs shall not exceed the maximum amount for the appropriate number of eligible children in the Kinship Care case as follows:

Number of Eligible Children	Maximum Payment Amount
1	$350
2	$700
3	$1050
4	$1400
5	$1,750
6 or more	$2,100

Start-up funds are not used for medical expenses. If a Kinship Care caretaker relative indicates a need for assistance with an expense named above, refer to P&P staff via form PAFS-628.

P. If child care assistance is requested, refer the Kinship Care caretaker relative to the area's service agent using form PAFS-86, Referral for Child Care. Eligibility for Kinship Care does not establish entitlement to a child care subsidy payment.

Q. An administrative hearing or service appeal in accordance with the P&P process may be requested by a Kinship Care caretaker relative who is denied:

1. Supportive services offered to facilitate the child's placement with the Kinship Care caretaker relative; or
2. Start-up costs offered to facilitate the child's adjustment to the new environment with the kinship caregiver.

R. A Kinship Care caretaker relative who is dissatisfied with an action or inaction on the part of the Cabinet relating to financial assistance under Kinship Care may request a hearing using the Family Support process.

Dietra Paris, Commissioner

INSTRUCTIONS FOR OPERATION MANUAL MAINTENANCE
PEN AND INK CHANGE (S)
VOLUME III

Cross-reference the following with: “OM Pol. Upd. No. 03-29, MS 99638, 8/1/03”. Page 5000 (R. 6/1/03), MS 5000 Page 5010-5020 (R. 6/1/03), MS 5010 and MS 5020 Page 5030-5050 (R. 6/1/03), MS 5030 Page 5090-5100 (R. 6/1/03), MS 5100	
VOLUME X	
REMOVE AND DESTROY	INSERT
	996388/1/03

MS 99631 KENPAC PROVIDER CHANGES

As a result of additional changes to KenPAC policy, this OM Policy Update supersedes OM Policy Update No. 02-27. This policy update contains information from the previous update and includes changes and additional policy clarifications. The policy changes include:

- The special request item, "The recipient has requested a provider outside of his/her medical service area", has been moved from form MAP-357C, KenPAC Primary Care Provider (PCP) Special Assignment Request Form to form MAP-357B, KenPAC Primary Care Provider (PCP) Change Form.
- Individuals requesting permission to change their Primary Care Provider (PCP) with form MAP-357B must select a PCP with an open quota.
- Special assignment of a newborn has been added to form MAP-357C. The newborn must be within the first 90 days of initial KenPAC enrollment.
- A new KenPAC exemption code has been added for individuals who are required to select a PCP for their private insurance.

Forms MAP-357B and MAP-357C have been revised to reflect the new policy and procedure changes. These are being issued by a forms transmittal.

A. During the application process, the applicant is given the opportunity to select a PCP. The individual may change that provider within the first 90 days of initial KenPAC enrollment. The 90 days of initial KenPAC enrollment begins with the first day of the month that the MAID is received with a provider assignment. The next opportunity to change a provider is at the annual renewal (recertification). Recipients are reminded of the opportunity to change PCP's through quarterly MAID inserts.

B. Special assignment procedures allow certain applicants and recipients that are in the 90-day KenPAC initial enrollment period to be assigned to a provider with a closed quota. Special assignment does not apply to requests made outside of the initial enrollment period. There are two types of special assignments for KenPAC initial enrollments. Ones that do not require PCP approval and ones that do require PCP approval.

    1. If a provider has a closed quota and there is a "Y" indicator, the provider is willing to accept additional assignments. Special assignments can be made without the KenPAC provider's approval in any one of the situations listed below:

        a. Request for reassignment by a former KenPAC patient who is reapproved for Medicaid within 180 days of the effective date of discontinuance;
        b. Reinstatement of a case within 180 days of the effective date of discontinuance;
        c. Request to add a newborn child of a current patient; or
        d. Request to add a spouse, child or sibling of a current patient included in the same case.

For items a. and b. above, KAMES will automatically reassign the applicant to their previous KenPAC provider. See item D. of the update for more information on the automatic reassignment. For items c. and d. above, the worker is to call the Medical Support and Benefits Branch (MSBB) in Quality Central at (502) 564-7050 to request the special assignment.

If a provider has a closed quota and there is an “N” indicator that the provider is not willing to accept additional assignments. The only special assignment that can be made to this provider is reassignment of a former patient within 180 days of discontinuance (items a. and b. above).

2. If a provider has a closed quota with a "Y" indicator, the following situations require provider approval:

   a. The member is a newborn (0-12 months) and his/her family has no prior patient history with the requested provider. Newborn is within 90 days of initial enrollment in KenPAC;
   b. The member has reapplied for Medicaid after 180 days of the effective date of discontinuance and is asking to be reassigned the KenPAC provider they were assigned to when discontinued.
   c. The member has applied for Medicaid and was a private-pay patient, or was a regular Medicaid patient, or managed care (Passport) patient of the provider prior to becoming subject to KenPAC enrollment.

3. If the individual meets one of the criteria in item 2. above, form MAP-357C is required to obtain the PCP’s permission. Complete form MAP-357C as follows:

   a. Complete section 1 with all member and provider information;
   b. Check the reason for special request;
   c. Sign the section verifying that the individual meets special assignment criteria;
   d. Applicant completes and signs section 2 (worker should assist if necessary);
   e. Give form MAP-357C to applicant/recipient to take to the provider for their approval;
   f. The provider will fax form to the Division of Family Support (DFS) according to instructions on the form; and
   g. DFS staff in Quality Central completes the special assignment.

   NOTE: Forms not initiated by a worker will not be accepted. Providers are no longer allowed to initiate this form.

C. It is important to complete the KenPAC selection at the time of application. At application:

1. Explain the KenPAC program and hearing rights;
2. Access the current list of KenPAC providers on KAMES to make the selection;

3. Explain the guidelines relating to KenPAC provider specialty and assist the applicant in selecting a PCP that is appropriate, e.g., pediatrician, OB/GYN, family practice;
4. Explain that providers may only be changed during the initial 90 day period of enrollment in KenPAC and then annually at renewal;
5. Explain that changes for a valid reason can be made at any time. Some requests may be approved by the worker, some may require Department for Medicaid Services (DMS) approval; and
6. Explain hearing and appeal rights.

D. KAMES automatically reassigns applicants to their previous KenPAC provider if reapplication is made within 180 days of Medicaid discontinuance. The provider number is automatically uploaded on the KenPAC screen. The only exceptions to this procedure are:

1. The provider is no longer under contract with KenPAC.
2. The provider is no longer practicing in the applicant's medical service area.
3. The individual is reapproved in a different case (e.g. child was in the mother's case and now receives in the Grandmother's case). In this situation, if a member requests their previous KenPAC provider and the provider has a closed quota, contact the Medical Support and Benefits Branch (MSBB) at (502) 564-7050. MSSB will make the assignment.

The individual can request a provider change and the worker can enter a new provider number that has an open quota. The provider number can be changed but cannot be removed unless the member meets appropriate KenPAC exemptions and the applicable exemption code is entered.

E. PCP change requests outside the initial 90-day KenPAC enrollment or the annual renewal may be processed by the DCBS worker ONLY under the following circumstances:

1. Recipient moved to a different county, changing the medical service area (MSA);
2. Auto-assignment for migrant worker/homeless, as recipient could not be notified;

3. If PCP leaves group or clinic, remains within MSA, and the recipient wishes to remain with this PCP;
4. PCP leaves group or clinic, recipient wishes to remain with original group or clinic;
5. Permanent unavailability of PCP, e.g., death or retirement of PCP, provider disenrollment of patient, provider no longer participating in KenPAC;
6. PCP moves practice outside recipient's MSA; client is required to pick new provider or make request for assignment out of medical service area through DMS;
7. Agency error, e.g., card is incorrect;
8. Recipient is in an eligibility category with a certification period longer than 12 months (e.g., case alternate programs to TMA) and the recipient has been a patient with current PCP at least 12 months.

To authorize the change, the new PCP must have an open quota. The individual may request the change in person or by telephone. It is important that workers only change a PCP for the above listed reasons.

F. Requests for PCP changes outside of the initial 90-day KenPAC enrollment or annual renewal that do not meet the above criteria, require approval by DMS. The requested PCP must have an open quota. Make the referral to DMS by completing form MAP-357B, KenPAC Primary Care Provider (PCP) Change Form. The procedure is:

1. Complete the top part of the form, which must include information about the current PCP and the requested PCP information;
2. The worker must verify and sign that the requested PCP has an open quota; and
3. Retain a copy in the case record.

G. If the form MAP-357B is completed in a face-to-face interview in the office, mail or fax the form to DMS.

H. If the request is made by telephone, complete the top half and mail it to the recipient. Then the recipient completes and sends the form to DMS according to the instructions.

NOTE: If the MAP-357B is mailed back or returned to the local office, forward it to DMS.

I. DMS staff will review MAP-357B and make one of the following decisions:

1. Approved – the assignment will be completed in QC. Form MAP-357B is returned to the recipient as approved and indicates when the new provider will appear on the Medicaid card.
2. Denied - DMS staff sends a denial letter, which includes instructions for requesting a reconsideration. If the decision is upheld, a second denial letter with a notice of hearing rights is mailed. Reconsiderations and hearings related to PCP changes are processed by DMS. Notification letters are mailed to the recipient with copies sent to the worker.

J. Unless there are extenuating circumstances, DMS will make their decision within 30 days. Inquiries by recipients regarding the status of requests made on form MAP-357B are to be directed to the Care Coordination Branch at (502) 564-9440 or to DMS Member Services at 1-800-635-2570.

K. No changes are made to the existing policy regarding recipients that fail to select a provider during the application process or are disenrolled by a provider. In both situations:

1. A system-generated notice is sent to the recipient with instructions to contact the local DCBS office within 10 days to select a new KenPAC provider;

2. If a new provider is not selected, the system assigns a provider and a notice is mailed to the recipient.

L. A new KenPAC exemption code has been created to exempt individuals who have a private health insurance plan that requires the individual to select a PCP. The individual must provide proof of insurance with the selected PCP. If verification is provided, the worker enters a "P" exemption code on the KenPAC provider screen.

Dietra Paris, Commissioner

INSTRUCTIONS FOR OPERATION MANUAL MAINTENANCE	
PEN AND INK CHANGES	
VOLUME I	
Replace the cross-references to "OM Pol. Upd. No. 02-27, MS 99598, 10/1/02" on the following with: "OM Pol. Upd. No. 03-23, MS 99631, 6/1/03". Page 0403 (7/15/01), MS 0403 Page 0410 (7/15/01), MS 0410 Page 0412 (R. 7/15/01), MS 0412 Page 0416 (7/15/01), MS 0416 Page 0421 (7/15/01), MS 0421	
VOLUME X	
REMOVE AND DESTROY	INSERT
99598 10/1/02	99631 6/1/03

MS 99627 SPEND DOWN CHANGES

See Addendum to OM Upd. No. 07-22, MS 99771, 10/1/07
See OM Upd. No. 07-22, MS 99771, 10/1/07
See OM Upd. No. 07-17, MS 99766, 8/1/07

Effective May 5, 2003, KAMES processing and caseworker procedures are changed for spend down applications. These changes are being implemented at the request of the Department for Medicaid Services (DMS) to streamline the process and to assure the integrity of spend down billings and payments.

A. Workers no longer complete form PA-8, MA Spend Down Letter. This form is now obsolete. Spend down liability information for Medicaid billings and payments is now transmitted directly to the DMS payment system by KAMES.

B. The KAMES spend down approval notice is revised to include the case level spend down liability amount. The case level spend down amount is the amount the member is obligated to pay on the date the spend down liability is met (the amount previously listed on form PA-8). For a family spend down case, this amount is the total of member liability amounts if more than one member has a liability amount on the date spend down eligibility is met. For a prior quarter spend down approval, the revised KAMES notice can display two case level spend down liability amounts and spend down coverage periods for split eligibility. Split eligibility can occur when medical expenses are incurred in the first and third months of the prior quarter and two separate spend down calculations are completed. See OM Vol. IVA, MS 2670.

C. The Medicaid Identification Card (MAID) issued for a spend down approval will include the wording, “Spend Down Medical Coverage” on the card. This annotation will also appear on the MAID Card Issuance History Inquiry screen as “REGULAR – SPEND DOWN”.

D. No notice is sent to the medical providers. It is the responsibility of recipients to notify their providers when they are approved for spend down coverage and to show their MAID to their providers so that Medicaid billing can take place. It is important that this responsibility be explained to the applicant during the application interview.

E. Under the new spend down procedures, payments to providers are changed. If there are multiple bills incurred by an individual on the date the spend down eligibility is met, the member spend down liability amount is applied to (deducted from) the bills in the order they are received by DMS for payment. The member spend down liability amount is not assigned to a specific provider as it has been in the past. The Department for Medicaid Services is notifying all Medicaid participating providers about this change in spend down payments.

F. If a recipient contacts the Agency regarding an outstanding bill after they have notified the provider of spend down eligibility and have submitted the MAID to the provider, advise the recipient to:
   1. Contact the provider to see if the provider has billed Medicaid for the service.

2. Determine if the billed amount is the member liability amount for the date of spend down eligibility.
3. If the individual has other billing questions, refer them to Medicaid Member Services at (800) 635-2570 for assistance.

G. Screen changes and a new medical expense type code are added to KAMES to accommodate the new spend down procedures.
   1. Medical expense type code "14 – PRIOR MEDICAL EXP" is added to the Application Medical Expense screen. This code is used to identify allowable unpaid medical expenses incurred prior to the established quarter. When using prior medical expenses to meet the spend down amount, always show the date the expense was incurred as the first day of the spend down quarter. If the spend down amount is met with prior medical expenses only, the member spend down liability will be $0.
      Reminder: Unpaid medical expenses from a prior quarter must be verified as still owed. If the bill has been written off or has been paid by a third party, it cannot be used. If verification cannot be provided that the bill is still owed, it cannot be used to meet the spend down liability.
   2. A new field, "SPD LIAB" (spend down liability) is added to the third General Member Information Inquiry screen. This field is uploaded with the member's spend down liability amount.
   3. The Spend Down Liability screen is revised to remove the "PA-8" heading and "Y" indicator.

H. Screen changes and notice text changes are made for spend down approvals by special circumstance transaction.
   1. A new field, "SPD LIAB" is added to the Special Circumstance - 1 screen. The worker enters each member's spend down liability amount. The member spend down liability amount is the amount the member is obligated to pay on the date the spend down eligibility is met (the amount previously listed on form PA-8).
   2. The Special Circumstance - 1 Inquiry screen is revised to add a "SPD LIAB" field to display the member spend down liability amount.
   3. The special circumstance notice for a spend down approval is revised to display case level spend down liability amount.

Dietra Paris, Commissioner

Instructions for Operation Manual Maintenance
Pen and Ink Change(s)
Volume I
Cross-reference the following with: "OM Pol. Upd. No. 03-20, MS 99627, 5/1/03". Page 0450-0456 (R. 11/1/98), MS 0450
~~Volume IVA~~
~~Cross-reference the following with: "OM Pol. Upd. No. 03-20, MS 99627, 5/1/03". Page 2730-2740 (R. 1/1/99), MS 2740~~

Volume VI		
Cross-reference the following with: "OM Pol. Upd. No. 03-20, MS 99627, 5/1/03". Page 3650-3680 (R. 5/1/97) MS 3680		
Volume X		
Remove and Destroy	Insert	
	99627 99627(2)	5/1/03 5/1/03
	99627(3)	5/1/03

MS 99621 MA KWP DISQUALIFICATION

See OMTL-329 , 4/1/09
See OMTL-304, 8/1/08
See OMTL-294, 6/1/08

Effective April 1, 2003, K-TAP recipients who are penalized for failing to participate in the Kentucky Works Program (KWP) will lose their Medicaid coverage. The first month medical assistance (MA) benefits are affected is May, 2003. There is no change to MA for individuals who are not required to participate in KWP activities. A one-time notice informing recipients of this change will be issued the week of March 17, 2003. A facsimile of this notice was provided to field staff with ELO 03-03-17.

A. For individuals penalized for failure to cooperate with KWP requirements after April 1, 2003, the MA KWP disqualification will be manually entered on KAMES once the 416 disqualification is imposed on STEP.

B. Imposing the MA KWP disqualification is a manual process entered on KAMES Disqualification File Menu, Option Q, from the KAMES Main Menu. Entry of the disqualification code for these individuals may begin April 1, 2003 to stop MA benefits effective May 1, 2003.

1. Disqualification code 431 – "MA KWP (K-TAP)" is used to impose the MA KWP disqualification.
2. When the 431 disqualification code is entered, workers will be asked to enter a member status source code on the Disqualification Add screen, HRKIMD0H. The code choices are:

   - H – Administrative Hearing
   - W – Waiver to Administrative Hearing (not valid for MA IPV)
   - C – Court Order
   - A – Disqualification Consent Agreement

   Enter code "A" in the "member status source code" field.

3. Once the disqualification code is entered on the system, the worker must complete an action that creates a recalculation process on the case to impose the disqualification. An action that creates a recalculation process would include:

   a. Updating a pending application,
   b. Updating a pending recert,
   c. Completing a case change, or
   d. Completing a "J" no change action.

4. Before the final disposition of any of the above actions, the worker will receive an override screen that allows entry of a "Y" or "N" to suppress issuance of MA benefits. Workers must enter "N" to ensure MA benefits are suppressed.

5. It is not necessary to manually issue a notice of negative action. The system will generate the appropriate notice.

C. The following actions are to be taken to ensure MA benefits are not issued for individuals who are currently penalized for failure to meet KWP requirements:

1. Review the Sanctioned Participants listing on STEP Case Management Reports to identify K-TAP recipients penalized for failure to cooperate with KWP requirements with an effective date prior to April 2003.

2. Prior to imposing a MA KWP disqualification for failure to cooperate with KWP requirements, schedule an appointment using form KW-204, Conciliation Contact, to discuss the change in policy and loss of benefits.

3. Individuals who do not agree to meet participation requirements are to have the MA KWP disqualification imposed effective May, 2003.

4. Individuals who agree to participate are to have a new assessment and Transitional Assistance Agreement (TAA) completed with a specific work goal and activity. Enter a cure begin date on STEP sanction screen.

5. Allow the individual ten work days to verify that the individual is complying with KWP requirements as agreed to on the TAA.

   a. If the individual does not verify within ten work days that KWP requirements are met, impose the MA KWP disqualification. Send form KW-211, Non-Compliance Contact.
   b. If it is verified that the individual is now complying with KWP requirements, do not impose the MA KWP disqualification.
   c. Monitor participation for two weeks as outlined in Volume IIIA, MS 4770, Curing the Penalty. Once the individual has successfully participated in an activity for two weeks, cure the penalty on STEP.

D. Pregnant individuals, for which a KWP pro rata penalty is imposed, remain deemed eligible for MA benefits through their pregnancy and postpartum period.

1. Enter the 431 MA KWP disqualification code on the system when a pregnant individual becomes penalized for failing to meet KWP work requirements. The system will not impose the MA KWP disqualification on a pregnant individual as long as the pregnancy information is entered and verified on KAMES. The system will impose the disqualification once the pregnancy information is removed from the system and the postpartum period has expired.

2. KAMES posts a spot check to the DCSR at the end of the postpartum period. Schedule an appointment with the participant to discuss KWP requirements. Review the case to determine the number of months the individual has used the exemption for caring for a child under the age of one.

3. If the individual chooses to use the exemption to care for a child under the age of one:

   a. Cure the KWP pro rata penalty on STEP using the procedures outlined in Volume IIIA, MS 4770.
   b. Ensure the "U" exempt code is entered on KAMES and that tracking screens reflect the use of the "U" code.
   c. Manually enter a spot check code "K - age tracking" to review the case in the month the 12-month exemption expires.
   d. Manually remove the "431" disqualification on KAMES to provide MA benefits.

~~E. Individuals whose K-TAP benefits are terminated due to 24-Month Work Policy as outlined in Volume III, MS 2004, 24-Month Work Policy, are not eligible for MA in the "E" or "T" category. Determine ongoing medical eligibility in any other medical category as outlined in Volume IV, MS 1070, Categories of Assistance. For cases discontinued due to 24-Month Work Policy prior to 4/1/03, who are currently active in the "E" or "T" category, review ongoing medical eligibility in the appropriate category at the next recertification.~~

~~F. Individuals whose K-TAP benefits are terminated for failing to complete an assessment interview as outlined in Volume IIIA, MS 4505, Assessment, are not eligible for MA in the "E" or "T" category. Determine ongoing medical eligibility in any other medical category as outlined in Volume IV, MS 1070. For cases discontinued for failing to complete an assessment prior to 4/1/03, who are currently active in the "E" or "T" category, review ongoing medical eligibility in the appropriate category at the next recertification.~~

G. Watch disposition screens on KAMES carefully to ensure the case is program transferred to the appropriate MA category.

Make every effort to engage a participant in meeting KWP requirements. Individuals who are penalized are to be brought in at the end of three months to discuss participation. If an individual states a willingness to participate in KWP activities, but no activity is available, a KWP penalty is not imposed and the MA KWP disqualification is not imposed. However, unavailability of a KWP activity should be rare. The worker is responsible for assisting the KWP participant in finding/identifying a KWP activity.

Dietra Paris, Commissioner

Instructions for Operation Manual Maintenance

Pen and Ink Change(s)	
Volume III	
Cross-reference the following with: "OM Pol. Upd. No. 03-16, MS 99621, 4/1/03". ~~Page 2004 (R. 6/1/99), MS 2004~~ ~~Page 2078 (R. 3/1/99), MS 2078~~ Page 2220-2225 (R. 6/1/99), MS 2225	
~~Volume IIIA~~	
~~Cross-reference the following with: "OM Pol. Upd. No. 03-16, MS 99621, 4/1/03".~~ ~~Page 4505 (6/1/98), MS 4505~~ ~~Page 4750-4770 (R. 6/1/99), MS 4770~~	
~~Volume IV~~	
~~Cross-reference the following with: "OM Pol. Upd. No. 03-16, MS 99621, 4/1/03".~~ ~~Page 1070 (R. 5/1/01), MS 1070~~ ~~Page 2310 (8/1/96), MS 2310~~ ~~Page 4300-4305 (R. 9/1/00), MS 4300~~	
Volume VI	
Cross-reference the following with: "OM Pol. Upd. No. 03-16, MS 99621, 4/1/03". Page 5500 (R. 3/1/03), MS 5500 Page 5550 (R. 8/1/98), MS 5550 Page 5565 (R. 5/1/97), MS 5565 Page 5660 (R. 3/1/03), MS 5660	
Volume X	
Remove and Destroy	Insert
	99621 4/1/03

ERRATA

MS 99621

MA KWP DISQUALIFICATION

See OMTL-329, 4/1/09
See OMTL-304, 8/1/08
See OMTL-294, 6/1/08

This errata is being issued to clarify policy concerning the MA KWP disqualification. These clarifications are the result of discussions with the Department for Medicaid Services.

A. Active K-TAP teen parents, up to age 19, are NOT subject to the MA KWP disqualification. These individuals are considered children for Medicaid eligibility purposes and, as such, are categorically eligible for medical assistance. Once the teen parent turns 19, he/she is subject to the MA KWP disqualification. When discussing KWP requirements with teen parents, be sure to explain the MA KWP disqualification policy so the individual is aware of the potential of losing MA benefits once he/she turns age 19.

   To ensure the disqualification is imposed in a timely manner for these individuals:

   1. Manually enter spot check type “K” – “age tracking” for the month the individual turns 19.

   2. Enter disqualification code 431 – “MA KWP (K-TAP)” on KAMES prior to cut-off in the month the individual turns 19.

   3. Document KAMES and STEP comments thoroughly regarding the age of the individual to explain why the disqualification is not entered at the time of the sanction.

B. Delete items E and F from OM Pol. Upd. 03-16, MS 99621. Individuals who are discontinued from K-TAP due to failure to comply with assessment requirements or 24-month work policy are not subject to the MA KWP disqualification. This is due to the fact that the KWP sanction is cured with the discontinuance of the K-TAP case. These individuals may qualify for medical assistance in the “E” or “T” category.

   1. Do not apply the MA KWP disqualification for failure to comply with assessment requirements.
   2. Cure the sanction and remove the 431 disqualification code prior to discontinuing the K-TAP case due to 24-month work policy.

C. It is imperative that the sanction is cured and the 431 disqualification code is removed prior to discontinuing the K-TAP case. This must be done to allow receipt of medical assistance.

D. If a 431 disqualification is imposed for an individual who later reports and verifies pregnancy information, enter the information on KAMES immediately. MA coverage for the current month must be issued via special circumstance.

Dietra Paris, Commissioner

INSTRUCTIONS FOR OPERATION MANUAL MAINTENANCE	
VOLUME III	
PEN AND INK CHANGE(S)	
Cross-reference the following with: "Errata to OM Pol. Upd. No. 03-16, MS 99621, 4/1/03". ~~Page 2004 (R. 6/1/99), MS 2004~~ ~~Page 2078 (R. 3/1/99), MS 2078~~ Page 2220-2225 (R. 6/1/99), MS 2225	
~~VOLUME IIIA~~	
~~Cross-reference the following with: "Errata to OM Pol. Upd. No. 03-16, MS 99621, 4/1/03".~~ ~~Page 4505 (6/1/98), MS 4505~~ ~~Page 4750-4770 (R. 6/1/99), MS 4770~~	
~~VOLUME IV~~	
~~Cross-reference the following with: "Errata to OM Pol. Upd. No. 03-16, MS 99621, 4/1/03".~~ ~~Page 1070 (R. 5/1/01), MS 1070~~ ~~Page 2310 (8/1/96), MS 2310~~ ~~Page 4300-4305 (R. 9/1/00), MS 4300~~	
VOLUME VI	
Cross-reference the following with: "Errata to OM Pol. Upd. No. 03-16, MS 99621, 4/1/03". Page 5500 (R. 3/1/03), MS 5500 Page 5550 (R. 8/1/98), MS 5550 Page 5565 (R. 5/1/97), MS 5565 Page 5660 (R. 3/1/03), MS 5660	
VOLUME X	
PEN AND INK CHANGE(S)	
Strike through items E and F in OM Pol. Upd. 03-16, MS 99621	
REMOVE AND DESTROY	INSERT
	99621 4/1/03 (ERRATA)

MS 99614

BENEFITS FOR CHILDREN OF WOMEN VIETNAM VETERANS

See OMTL-268, 1/1/06

Section 401 of the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, provided for certain benefits for individuals with covered birth defects who are the natural children of women veterans who served in Vietnam during the Vietnam era. There is no age limit for recipients of these benefits. These individuals receive the benefits until they die.

For K-TAP, Food Stamp and Medicaid Programs the amount of these Vietnam veterans benefits are considered as excluded income and resources. At the next case action, review the case for this type of income and exclude if applicable. Issue supplements for any months from the effective date of 3/1/03.

Dietra Paris, Commissioner

Instructions for Operation Manual Maintenance	
Pen and Ink Change (s)	
Volume II	
Cross-reference the following with: "OM Pol. Upd. No. 03-11, MS 99614, 3/1/03". Page 5200-5210 (R. 10/1/02), MS 5210	
~~Volume III~~	
~~Cross-reference the following with: "OM Pol. Upd. No. 03-11, MS 99614, 3/1/03". Page 2510 (R. 5/1/01), MS 2510~~	
~~Volume IV~~	
~~Cross-reference the following with: "OM Pol. Upd. No. 03-11, MS 99614, 3/1/03". Page 3850 (R. 9/1/00), MS 3850~~	
~~Volume IVA~~	
~~Cross-reference the following with: "OM Pol. Upd. No. 03-11, MS 99614, 3/1/03". Page 2470 (R. 9/1/00), MS 2470~~	
Volume X	
Remove and Destroy	Insert
	99614 3/1/03

MS 99613 KENPAC FOR GALLATIN AND HANCOCK COUNTIES

Starting in March 2003, Gallatin and Hancock counties are no longer exempt from KenPAC. The change from non-KenPAC to KenPAC will be phased in over a 6-month period. This change brings all counties into either KenPAC or Managed Care, which assists with cost savings and better health care for recipients.

Dietra Paris, Commissioner

<table>
<tr><td colspan="2">Instructions for Operation Manual Maintenance</td></tr>
<tr><td colspan="2">Pen and Ink Changes(s)</td></tr>
<tr><td colspan="2">Volume I</td></tr>
<tr><td colspan="2">Cross-reference the following with: “OM Pol. Upd. 03-10, MS 99613, 3/1/03”.
Page 0403 (R. 7/15/01), MS 0403</td></tr>
<tr><td colspan="2">Volume X</td></tr>
<tr><td></td><td>Insert</td></tr>
<tr><td></td><td>99613 3/1/03</td></tr>
</table>

99564 MEDICAL REVIEW TEAM EXPANSION

Effective 8/1/01, Medical Review Team (MRT) services are expanded to all counties statewide. These procedures apply to all K-TAP incapacity, KWP good cause, and MA disability/incapacity claims. This will include ONLY pending applications taken 8/1/01 and after, and all redeterminations due in 8/01 and after for the remaining counties added effective 8/1/01. MRT will not complete the medical development process on applications prior to 8/1/01. These will be returned to the local office for completion. After 8/1/01 form PA-601 will be obsolete.

A. The MRT project is designed to:

1. Reduce the caseworker's responsibilities regarding incapacity/disability determinations sent to MRT;

2. Reduce processing time from the date of application; and

3. Transfer the responsibility for obtaining medical records for incapacity/disability cases from the local family support staff to MRT.

B. The process for incapacity/disability determination requests are as follows:

1. Complete form PA-601T, Referral for Determination of Incapacity or Disability. This information should be completed in as much detail as possible. Forms PA-601T with incomplete documentation will be returned to the caseworker for completion and this will delay the process.

2. Obtain the patient's signature on several PAFS-15 (with a revision date of 5/01 or after) forms, Authorization for Information/Release of Information. Have at least one signed form for each medical source plus at least one extra. These forms must be signed by the patient and witnessed by the caseworker.

3. Mail form PA-601T and the signed PAFS-15 forms to MRT immediately upon completion. Include only the medical information the individual has provided. For redeterminations, remember to send MRT the old PA-6 and medical records used in making that determination as well as the updated PA-601T and signed/witnessed PAFS-15s with the current date.

   Assist MRT if additional clarification or information is needed from the individual. If MRT can reach the individual by phone, they will do so.

C. MRT has compiled the following tips concerning the completion of this process.

1. Annotate PA-601T forms if the case is Kentucky Works. *This is very important*. MRT codes KWP and incapacity cases differently in their computer system. The rationales are worded differently and criteria for making the decision are looked at differently. Under the status section of the PA-601T, there should be an option to check for Kentucky Works. If this is not on your form, request copies of forms revised 4/99.

2. Send old medical information and a copy of the decision from the last MRT determination, if appropriate. This is probably the number one reason why a case is returned to the local office without a medical decision. If the case is being sent in for redetermination or if MRT has made a decision within the past year, send the old PA-6/PA-610 along with the medical information used for that decision. MRT examiners use this as a reference and documentation of medical history. MRT can also see what has been requested in the past to avoid sending duplicate requests to treating sources.

3. Use the most current version of form PAFS-15. Using an older version can cause an unnecessary delay in processing the determination. PAFS-15 forms should be filled out correctly in their entirety. Make sure the *patient* signs the PAFS-15 where it says “Applicant/Recipient”. Sources do not accept a spouse’s signature in place of the patient’s. MRT needs *original signatures* on *each* PAFS-15. Do not make copies. The caseworker should sign *each* PAFS-15 as a witness. More and more vendors are returning these forms for a witness signature before releasing the records. This increases processing time for the client. Be sure to include one PAFS-15 for each medical source listed on the PA-601T and keep at least one extra for the file.

4. Fill out page one of the PA-601T in its’ entirety. Do not skip any items. Frequently the date of birth, county name and number, town, zip code, and/or phone number is omitted. Be sure to include the case type (C, E, L or M) with case number so MRT will not have to stop and call the field worker for this information.

5. If you are handwriting a PA-601T, please write legibly.

6. Fill out page two of the PA-601T in detail. MRT is not always familiar with names of doctors, clinics, addresses, and hospitals in all counties of the state. For this reason, it is very important to include the doctor’s first and last name and use the correct spelling. Include the complete address and phone number. MRT uses a computer program to request medical records and they have to input the name of the doctor/clinic/hospital and the town where their office is located. If the name is spelled

wrong or the locale is incorrect, the computer cannot find that particular source. If the doctor is in a clinic or group, MRT also needs the name of the group/clinic.

7. Include dates of treatment for all sources listed. This is also very important. Often times the date of treatment is left blank or filled out "don't know". MRT requests medical information that is relevant to making a medical decision. If a person was seen by a doctor or at a hospital over one year ago, it is generally irrelevant and MRT does not request that record. If MRT is working on a case that is a redetermination, they will only request records from sources seen since the last decision. If the client cannot remember specific dates, try to pin him down to a specific time period such as last month, within the last 6 months, not in the last year, etc. This will be much more help than "don't know" or blank.

8. Complete a new PA-601T every time a case is submitted to MRT either for a redetermination or as a new application. Interview the client and list only medical sources seen since the last PA-601T was completed. Send the prior MRT records along with this new PA-601T; therefore, MRT will have the old information on the previous PA-601T. This will save field staff time and will save MRT from requesting duplicate medical records.

Dietra Paris, Commissioner

Instructions for Operation Manual Maintenance

Pen and Ink Changes

Volume III

Cross-reference the following with "OM Pol. Upd. 01-16, MS 99564, 8/1/01":

Page 2377 (R. 3/1/99), MS 2377
Page 2379 (R. 10/1/98), MS 2379
Page 2381 (R. 10/1/98), MS 2381
Page 2383 (R. 3/1/99), MS 2383

~~Volume IV~~

~~Cross-reference the following with "OM Pol. Upd. 01-16, MS 99564, 8/1/01":~~

~~Page 2570 (R. 11/1/98), MS 2570~~
~~Page 2570-2580 (R. 11/1/97), MS 2580~~
~~Page 2585 (8/1/96), MS 2585~~
~~Page 2590 (8/1/96), MS 2590~~

~~Volume IVA~~

~~Cross-reference the following with "OM Pol. Upd. 01-16, MS 99564, 8/1/01":~~

~~Page 1700-1720 (8/1/96), MS 1710~~
~~Page 1700-1720 (8/1/96), MS 1720~~
~~Page 1730 (8/1/96), MS 1730~~
~~Page 1730-1740 (R. 11/1/96), MS 1740~~
~~Page 4650-4662 (R. 5/1/01), MS 4662~~
~~Page 4752-4753 (R. 5/1/01), MS 4753~~
~~Page 4950-4960 (8/1/96), MS 4960~~

Volume X

Remove and Destroy		Insert	
99519	3/1/00	99564	8/1/01

(OM Pol. Upd. 00-05)

MS 99553

TIMESHEETS AND FAMILY SUPPORT PROGRAM CODES

See OM Upd. No. 06-23, MS 99742, 9/16/06

Beginning 5/1/01, there are revised procedures concerning how time spent on the various Family Support programs is entered on the timesheet. The revised timesheet procedures apply to all staff who are involved in eligibility and benefit determinations. These revised procedures are necessary to accurately allocate time spent on each program as required by the Department of Health and Human Services.

Start using these revised procedures effective 5/1/01.

A. As a result of the revised procedures, three new program function codes have been developed. These new program codes are used along with existing program codes. The new common program codes are:

1. TANF/FS/MA - ZAZA;
2. FS/MA - ZAZB; and
3. TANF/MA - ZAZC.

The new codes identify time spent on tasks that involve information shared between programs. Shared information consists of data elements which are common to more than one program. The common data elements are:

- Name;
- SSN ;
- Date of birth;
- Address, both residence and mailing;
- Telephone number, both primary and secondary;
- County of residence;
- Demographic information - sex, race, language, nationality, citizenship, marital status, highest grade completed in school;
- Disability indicator;
- Resources;
- Income; and
- Private health insurance indicator.

EXAMPLE: A family is applying for Food Stamps and Medicaid at the same time. Since both applications share common data elements (e.g., name, address, date of birth, etc.), the time spent gathering and entering these common data elements is coded to ZAZB and the other time spent on the applications is coded to each specific program.

B. In addition, the revised procedures require that the program code information be documented in half-hour intervals. Form P-4S, Timesheet Addendum for Detailed Program Code Documentation, was created to provide a means of documenting this information.

1. Every half-hour, enter the appropriate program code for the task being done in that half-hour. In addition, enter the case

number that is involved in the activity. If more than one case is involved, enter all the case numbers involved.

2. If more than one activity is done in the half-hour interval, enter the code for the program that accounted for the majority of the time.
3. At the end of the day, transfer the program code information to the timesheet, form P-4, Employee Time Reporting.
4. At the end of the pay period, attach the forms P-4S for that pay period to the timesheet. The supervisor reviews the timesheet and addendums to ensure the program code information shown on the addendums is accurately reflected on the timesheet.

C. Time coding for KCHIP applications must be coded in the following manner.

1. Code time spent on KCHIP denials to the KCHIP program code, ZACR.
2. If, at the disposition of the application, the child is approved for KCHIP, code the time spent on processing the application to the KCHIP program code, ZACR.
3. If, at disposition of the application, the child is approved for Medicaid instead of KCHIP, code the time spent on processing the application to the MA program code, ZACA.
4. If the application contains more than one child and some children are approved Medicaid and some are approved KCHIP, code the time spent on processing the application to the majority program.
   EXAMPLE: The application is approved for four children - one child is MA and the other three are KCHIP. The time is coded to ZACR.

To determine how to code the time spent on the KCHIP/MA application, you can inquire KAMES, Member General Information after approval to find out the recipient status code (P1, P2, P3, etc.). The recipient status code indicates if the child was approved as Medicaid or KCHIP. You can also base the decision on the situation of the child. If the income is within the highest "I" category income level, then the time would be coded to Medicaid.

Dietra Paris, Commissioner

Instructions for Operation Manual Maintenance

Pen and Ink Changes

Volume I

Cross-reference the following with: "OM Pol. Upd. 01-05, MS 99553, 5/1/01".

Page 0177-0180 (R. 9/1/00), MS 0180
Page 0183 (R. 9/1/00), MS 0183
Page 0186 (R. 9/1/00), MS 0186
Page 0189-0195 (R. 9/1/00), MS 0189

Volume X

Remove and Destroy	Insert	
	99553	5/1/01
	99553(2)	5/1/01
	99553(3)	5/1/01

MS 99548 TMA RECERTIFICATION EXPANSION

Effective 12/1/00, the following changes are to be implemented in TMA processing. These changes are being made in order to assure that eligible children and families continue to receive medical coverage.

TMA cases must be reviewed to determine if any member of the household is ongoing eligible for benefits in any category of Medicaid.

A. In the 11th month of TMA, a KIP-2SR, Recertification Notice for KCHIP and Family Related MA, is system generated to the recipient. Field staff are to follow mail-in recertification procedures outlined in OM Policy Update 00-14.
B. In the 12th month of TMA, when the KIP-2SR is received, or if the client completes a face-to-face interview, the worker is to manually prescreen the income reported prior to entering a recertification action on KAMES. If the family is eligible in the E or T category, the worker must enter a program transfer. Do not enter a recertification action in this situation.
C. If the KIP-2SR is not received and entered on the system by the 10th day of the 12th month of TMA, a KIP-2SRA is mailed out by the system on that date. The recipient has until cut-off to return the KIP-2SRA. If the KIP-2SRA is not received and entered by cut-off, the TMA case discontinues and no MA-105 is necessary.
D. If the household does not qualify for ongoing medical coverage or fails to return the KIP-2SRA, and contains a deemed eligible or postpartum member, the case remains active as an "I" case only. The certification period is extended until the month the deemed eligible member turns one year old or the month the 60-day postpartum period ends.

Dietra Paris, Commissioner

Instructions for Operation Manual Maintenance

Pen and Ink Changes

Volume VI

Cross-reference the following with: "OM Pol. Upd. 00-34, MS 99548, 11/16/00."
Page 4255 (R. 4/1/98), MS 4255
Page 4305 (R. 5/1/97), MS 4305

Volume X

Remove and Destroy	Insert	
	99548	11/16/00
	99548 (2)	11/16/00